

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08130

08132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>VA.</u> b. COUNTY <u>HANOVER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>ASHLAND</u> 83X-3	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Abraham</u> Last <u>S</u>		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1929</u>
9. AGE (In years last birthday) <u>27 3/4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>HANOVER Co. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MONTAGUE ABRAMS</u>		14. MOTHER'S MAIDEN NAME <u>JULIA SHELTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JANE ABRAMS</u>		Address <u>ASHLAND VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Choking</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>850X</u> (c) <u>Stroke</u> INTERVAL BETWEEN ONSET AND DEATH <u>Stroke</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Back turned over</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>5-11-57</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>James Rk</u>		20f. (City or town) (County) (State) <u>ASH</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. W. HART</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. W. HART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>8-11-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-16-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FAMILY PLOT</u>		22d. LOCATION (City, town, or county) (State) <u>ASHLAND VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DABNEY FUNERAL HOME</u>		ADDRESS <u>Box 528 ASHLAND VA</u>	
24a. REG. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>W. M. HART</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

19185

BUREAU V. 5

AUG 13 1957

RECEIVED

08131

CERTIFICATE OF DEATH

Reg. Dist. No. 0813321

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 Calvert St.</u>				d. STREET ADDRESS <u>77 Calvert St.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles T Adams</u> First Middle Last				4. DATE OF DEATH <u>8</u> Month <u>6</u> Day <u>1957</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-1914</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bus Cab Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Adams</u>				14. MOTHER'S MAIDEN NAME <u>Roseella Modack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-8426</u>		17. INFORMANT <u>Ada Adams - Annapolis, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Myocardial Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart disease</u> DUE TO <u>1 year</u> (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1, 1956</u> , to <u>August 6, 1957</u> , that I last saw the deceased alive on <u>August 2, 1957</u> , and that death occurred at <u>4:35 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u>				ADDRESS (Street, city or town, state) <u>110-Clay St ANNAPOLIS</u>		DATE SIGNED <u>8/7/57</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-9-57</u>		<u>Brewer's Hill</u>		<u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		TREATMENT	
DATE OF INTERMENT		PLACE OF INTERMENT	
SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED	
DATE OF REGISTRATION		PLACE OF REGISTRATION	
FEE		REMARKS	

BUREAU V. 8

AUG 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08134
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 24
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 612 New Jersey Avenue					d. STREET ADDRESS 612 New Jersey Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First PAUL Middle NORBERT Last ALBRECHT					4. DATE OF DEATH Month August Day 27 Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 7, 1957		9. AGE (In years last birthday) 7 wks.		
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Arundel Gen'l Hosp. MD. U.S.A.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Herbert Albrecht					14. MOTHER'S MAIDEN NAME Johanna Kroll					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Herbert Albrecht Same As No. #2						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Otitis Media. 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE 					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.					DATE SIGNED 7/27/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29, 57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton					ADDRESS Glen Burnie		24a. REC'D BY REGISTRAR AUG 30 1957		24b. REGISTRAR'S SIGNATURE L. J. DeAlba	

2063251XV4

RECEIVED

Paul F. Davis

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08135

08170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALE BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALE BEACH</u>	
c. LENGTH OF STAY IN 1b <u>4 YRS</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY Franklin ANDERSON JR.</u>		4. DATE OF DEATH Month Day Year <u>AUG 24 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 27, 1953</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY ANDERSON</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Estell Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNED</u> <u>929.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c), stating the underlying cause lost. (c) <u>—</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FELL FROM WHARF INTO WATER</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>445 8/24/57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>	20f. (City or town) (County) (State) <u>DEALE BEACH ANNE ARUNDEL MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Edward S Beck</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/6/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-27-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Galesville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardesty, Galesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 9 57</u>	
24b. REGISTRAR'S SIGNATURE <u>Quinn</u>			

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FBI
SEP 10 1957

BUREAU V. S.

SEP 9 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08171

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sherwood Forest	c. LENGTH OF STAY IN b 2 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 1231.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #4 Beach Drive		d. STREET ADDRESS #452 W. Bel Air Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First GEORGE Middle HAROLD Last BAKER		4. DATE OF DEATH Month Aug. Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Canner		10b. KIND OF BUSINESS OR INDUSTRY Canner/Corn	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James B. Baker	
14. MOTHER'S MAIDEN NAME Frances R. Richardson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes War I.	
16. SOCIAL SECURITY NO. 216-18-7924		17. INFORMANT Address #452 W. Bel Air Mrs. Geo. Harold Baker, Sr. Aberdeen, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic H.D. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH Acute Known 8 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Edward Leach M.D.		ADDRESS (Street, city or town, state) 14 E. Eager St DATE SIGNED 8/4/57	
PHYSICIAN'S NAME (Type) C. EDWARD LEACH		Baltimore 2 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/1957	22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	22d. LOCATION (City, town, or county) (State) Aberdeen, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. [Signature] ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR Aug 5-57	24b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU A. S.

AUG 7 1957

RECEIVED

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VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3Y01-4</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessup</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 1. Md</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland House of Convalescent Hospital</u>					d. STREET ADDRESS <u>621 George St</u>				
3. NAME OF DECEASED (Type or print) First <u>Tessie</u> Middle <u>Banks</u> Last <u>Banks</u>					4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1957</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/28-00</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>Andrew Banks</u>					14. MOTHER'S MAIDEN NAME <u>Lucy Johnson</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. <u>214-36-3369</u>				
					17. INFORMANT <u>Marie Banks, Wife</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
22a. ACTUAL SIGNATURE <u>William J. Mays</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type)					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22b. DATE THEREOF <u>Aug 20/57</u>					22c. NAME OF CEMETERY OR CREMATORY <u>1st Auburn Baltimore Md.</u>				
22d. LOCATION (City, town, or county) (State)					24a. REC'D BY REGISTRAR <u>Aug 20 1957</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eugene H. Mays</u> ADDRESS <u>609 George St</u>					24b. REGISTRAR'S SIGNATURE <u>Clara J. Hays</u>				

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS - CERTIFICATE OF DEATH

BUREAU V. S.

AUG 20 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08138

24

Reg. Dist. No.

08173

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Conv. Home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>G. 9</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Skidmore</u> STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>W.</u> (Middle) <u>BARNES</u> (Last)		4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>22</u> (Year) <u>1957</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>1-29-1874</u>	9. AGE last birthday <u>86</u> yrs.	10. UNDER 1 YEAR (Months) <u>8</u> Days <u>24</u> Hours <u>57</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John St. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Cissie Stansbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-17-57</u> to <u>8-22-57</u> , that I last saw the deceased alive on <u>8-1-57</u> , 19 <u>57</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above. <u>8-22-57</u>							
SIGNATURE <u>Joseph Walter</u>		M.D. <u>102 Bx A Blvd. N.E. Glen Burnie Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>8-25-57</u>		NAME OF CEMETERY OR CREMATORY <u>Broadneck</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. Sealy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Lynne, Md.</u>			
DATE <u>5/27/57</u>				ADDRESS			

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS MISCELLANEOUS

PREVIOUS OTHER

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PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

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PREVIOUS UNKNOWN

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BUREAU V. 4

JUL 27 1957

RECEIVED

08132

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis 10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1029 Smithville Street</i>		d. STREET ADDRESS <i>1029 Smithville Street</i>	
3. NAME OF DECEASED (Type or print) <i>Mary Ellen Bias Bell</i>		4. DATE OF DEATH Month <i>8</i> - Day <i>31</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-3-1891</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Francis Bias</i>		14. MOTHER'S MAIDEN NAME <i>Mary Watkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sub Acute Myocardial</i> <i>431X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Arterial Hypertension</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>March 15, 1957, to 8/30/57</i> , that I last saw the deceased alive on <i>8/30/57</i> , and that death occurred at <i>11:15 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>110-CLAY ST ANNAPOLIS, MD.</i> DATE SIGNED <i>8/3/57</i>		
ACTUAL SIGNATURE <i>R. H. Richards</i> M.D.		
PHYSICIAN'S NAME (Type)		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY
<i>Burial</i>	<i>2-4-57</i>	<i>Brewer Hill</i>
22d. LOCATION (City, town, or county) (State)		
<i>Annapolis Md.</i>		
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
<i>SEP 6 1957</i>		<i>Wm J. French</i>
GENERAL DIRECTOR'S SIGNATURE ADDRESS <i>William Reese, Jr. Annapolis, Md.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF MINISTER OF THE GOSPEL		15. SIGNATURE OF CORONER	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF CHIEF CLERK		19. SIGNATURE OF ASSISTANT CLERK		20. SIGNATURE OF DEPUTY CLERK	

BUREAU V. S.

SEP 6 1957

RECEIVED

Received at 12-21
 Baltimore, Maryland
 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08140

08133

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Severna Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>1 Manhattan Beach</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Paige</u> Last <u>BENNINGTON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>24 April 1900</u>		9. AGE (In years last birthday) <u>57</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Thomas Jefferson BENNINGTON</u>				14. MOTHER'S MAIDEN NAME <u>Marion Irene LATTARNER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>577-42-5422</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____, 19 ____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>23 May</u> , 19 <u>57</u> , to <u>24 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>24 August</u> , 19 <u>57</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Frederick W. Meyer, Jr.</u> M.D. <u>U.S. Naval Hospital, Annapolis, Md. 8-26-57</u> PHYSICIAN'S NAME (Type) <u>Frederick W. MEYER, Jr.</u> Commander, Medical Corps, U.S. Navy							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>John J. Church</u>	

CERTIFICATE OF DEATH

File No. 114

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Place of Birth	
Date of Birth		Manner of Death		Medical History	
Physician's Name		Hospital Name		Burial Place	
Signature of Physician		Signature of Registrar		Signature of Coroner	

BUREAU V. S.

AUG 28 1917

RECEIVED

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Place of Birth	
Date of Birth		Manner of Death		Medical History	
Physician's Name		Hospital Name		Burial Place	
Signature of Physician		Signature of Registrar		Signature of Coroner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08134 CERTIFICATE OF DEATH

Reg. Dist. No.

08141

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp. -</u>		d. STREET ADDRESS <u>Herald Harbor</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Thekla</u> Middle <u>Frieda</u> Last <u>Boschen</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1897</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR: Months <u>60</u> Days <u>13</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fritz Castens</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Peters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Herald Harbor</u> <u>Mr. Henry Boschen - Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripancreatic abscess</u> <u>584x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute pancreatitis</u> DUE TO (c) <u>Calculi in Common duct.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>8-10 days.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/26/57</u> , 19 <u>57</u> , to <u>8/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/13/57</u> , 19 <u>57</u> , and that death occurred at <u>10:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>2. Borowski</u> M.D. <u>Amos Garrett Borowski</u> <u>8/13/57</u> PHYSICIAN'S NAME (Type) <u>S. Borowski</u> <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory Prince Georges Co. Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. A. Finer Co.</u>		24. REC'D BY REGISTRAR <u>15 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr. J. French</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. SIGNATURE OF PHYSICIAN [Faint text]	
11. SIGNATURE OF REGISTRAR [Faint text]		12. DATE OF DEATH [Faint text]	
13. PLACE OF DEATH [Faint text]		14. SIGNATURE OF WITNESS [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF NEXT OF KIN [Faint text]	
17. SIGNATURE OF BURIAL OFFICER [Faint text]		18. SIGNATURE OF CHURCH OFFICER [Faint text]	
19. SIGNATURE OF MINISTER [Faint text]		20. SIGNATURE OF CLERGYMAN [Faint text]	
21. SIGNATURE OF CHURCH OFFICER [Faint text]		22. SIGNATURE OF CLERGYMAN [Faint text]	
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97. SIGNATURE OF CHURCH OFFICER [Faint text]		98. SIGNATURE OF CLERGYMAN [Faint text]	
99. SIGNATURE OF CHURCH OFFICER [Faint text]		100. SIGNATURE OF CLERGYMAN [Faint text]	

RECEIVED
JUN 15 1957
BUREAU V. 2

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08174

CERTIFICATE OF DEATH

0814224
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Gibson Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Jeannette</u> Middle <u>Russell</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1881</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (rtd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Christopher E. Russell</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Virginia -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mr. W. H. Jory - Gibson Island, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 ACUTE PULMONARY Edema</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> causes, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs 50 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 25, 1957</u> to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 25, 1957</u> , and that death occurred at <u>10:50</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>William B. Lyons</u>		M.D. <u>Paisley Rd. Gibson Island Md. Aug 25, 1957</u>					
PHYSICIAN'S NAME (Type) <u>William B Lyons</u>		<u>PAISLEY RD, Gibson Island Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons</u>				ADDRESS <u>Balto., Md.</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Seally</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

MARYLAND

DEATH - MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

ULTIMATE CAUSE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

DATE OF ONSET

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

DATE OF EXHUMATION

DATE OF REINTERMENT

BUREAU V. 2

AUG 28 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08143

08175

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside Corporate limits, write RURAL and give nearest town) <u>Severn</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside Corporate limits, write RURAL and give nearest town) <u>Severn</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 27 - R# 2</u>				STREET ADDRESS (If rural give location) <u>Box 27, Route 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>John E.</u> (Middle) <u>Boyer</u> (Last) <u>Boyer</u>				(Month) <u>Aug</u> (Day) <u>9</u> (Year) <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 17 1893</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Severn Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chas. Webster Boyer</u>				14. MOTHER'S MAIDEN NAME <u>Alma Friedhopper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-124550</u>		17. INFORMANT & ADDRESS <u>Naomi Boyer (Wife)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>				<u>2-3 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/15/57</u> , 19 <u>57</u> , to <u>8/9/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/9/57</u> , 19 <u>57</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball Jr.</u>				M.D. <u>L. L. Litchner</u> DATE SIGNED <u>8/9/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/12/57</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>8/12/57</u>		REGISTRAR'S SIGNATURE <u>L. J. Schick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker</u> ADDRESS <u>North Pa. Ave</u>			

00143

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

CERTIFICATE OF DEATH

00143

Reg. No. 10

1. FULL NAME OF DECEASED

DECEASED

2. PLACE OF DEATH

PLACE OF DEATH

CO. 5

REG. NO. 10

3. DATE OF DEATH

DATE OF DEATH

4. TIME OF DEATH

TIME OF DEATH

5. PLACE OF BIRTH

PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

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BUREAU V. S.

AUG 13 1957

RECEIVED

ENCLOSURE

08176

CERTIFICATE OF DEATH

08144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Davidsonville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt 1 Box 35 A.		d. STREET ADDRESS Rt 1 Box 35 A.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BEAIR McKEAN BROOKS		4. DATE OF DEATH Month AUGUST Day 24 , Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1896
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11. BIRTHPLACE (State or foreign country) Suffolk, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brooks		14. MOTHER'S MAIDEN NAME Louise Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 374 22 5918	
17. INFORMANT Mrs Helene H. Brooks, Wife		Address same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerosis 420.1 DUE TO Coronary Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery (c) Coronary Artery		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 57 , to Aug , 19 57 , that I last saw the deceased alive on Aug 24 , 19 57 , and that death occurred at MD , from the causes and on the date stated above.			
ACTUAL SIGNATURE Elmer G. Linhardt		DATE SIGNED Aug 28 57	
PHYSICIAN'S NAME (Type) Elmer G. Linhardt MD		Annapolis, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF August 28, 57	22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cem.	22d. LOCATION (City, town, or county) (State) Annapolis, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR Aug 28 57	
ADDRESS Annapolis, Maryland		24b. REGISTRAR'S SIGNATURE Aug 28 57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

John Brooks

Davidsonville

Davidsonville

Box 12 A

Box 12 A

BLK

BRIDGE

White

White

John Brooks

John Brooks

John Brooks

Yes

Yes

Yes

BUREAU V. 2

AUG 28 1957

Annapolis, Maryland

Annapolis, Maryland

Annapolis, Maryland

Annapolis, Maryland

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08135

CERTIFICATE OF DEATH

08145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. Naval Hospital</u>				d. STREET ADDRESS <u>922 Windsor Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>BROWN JR</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21 June 1871</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHIEF CARPENTER MATE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM H BROWN</u>				14. MOTHER'S MAIDEN NAME <u>MARY STALLINGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>U. S. Naval Hospital, Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 May</u> , 19 <u>57</u> , to <u>5 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5 August</u> , 19 <u>57</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>8-6-57</u> ACTUAL SIGNATURE <u>M. J. Miller</u> M.D. PHYSICIAN'S NAME (Type) <u>M. J. MILLER</u> <u>LT. MC, USNR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Annes Cemt</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/7/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V. 5.

AUG 8 1957

RECEIVED

1
10
0
2
1
VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08177

CERTIFICATE OF DEATH

Reg. Dist. No.

08146

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 4yrs.1mo.16da.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month 8 Day 24 Year 19 57		5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-1886		9. AGE (In years last birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receipting Public Asst.		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John Buckner		14. MOTHER'S MAIDEN NAME Mary Elizabeth Buckner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT Hospital Records Crownsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Senility		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Crownsville, Md.		(County) (State)	
21. I certify that I attended the deceased from February 8-24 , 19 57 , to 8-24 , 19 57 , that I last saw the deceased alive on 8-24 , 19 57 , and that death occurred at 10:25 M, from the causes and on the date stated above.		22a. BURIAL CREMATION, REMOVAL (Specify) 8-28-57		22b. DATE THEREOF 8-28-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Co. 1432 You St. N.W.		24a. REC'D BY REGISTRAR DATE 28 1957		24b. REGISTRAR'S SIGNATURE H. M. Joyce		24c. ADDRESS Crownsville, Md.		24d. DATE SIGNED 8-26-57	

#178

BUREAU V. 5

AUG 28 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u> c. LENGTH OF STAY IN 1b <u>Few minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>On Old Telegraph Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3401-4</u> d. STREET ADDRESS <u>2116 W. Saratoga</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gilbert Burgess</u> First Middle Last <u>S.</u> <u>Burgess</u>		4. DATE OF DEATH Month Day Year <u>August 26th.</u> <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/17/13</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver - U.S. Gov't-heavy duty</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>motor pool</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Burgess</u>		14. MOTHER'S MAIDEN NAME <u>Annie Simpson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes 11 World War.</u>		16. SOCIAL SECURITY NO. <u>193-01-2281</u>	
17. INFORMANT <u>Mrs. G. Burgess (wife)</u>		Address <u>2116 W. Saratoga-Balt</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c) <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED <u>8/26/57</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr</u>		ADDRESS <u>Balto</u>	
24a. REC'D BY REGISTRAR <u>AUG 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Taylor</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. A.

AUG 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 219 8-29-57 et.

08179

CERTIFICATE OF DEATH

08148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>2yrs. 11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		d. STREET ADDRESS <u>Cheltenham, 16 x 12</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Edward</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-70</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Leila L. Campbell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443x Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive and Arteriosclerotic Cardio-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>- - - - -</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>August 21, 1957</u> , that I last saw the deceased alive on <u>8-21, 1957</u> , and that death occurred at <u>7:10a. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>8-21-57</u>			
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u>		M.D. <u>Crownsville State Hospital</u>	
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u>		<u>Crownsville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-24-57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Better</u>		ADDRESS <u>1203 Walter St.</u>	
24a. REC'D BY REGISTRAR <u>26 1957</u>		24b. REGISTRAR'S SIGNATURE <u>K.M. Joyce</u>	

08180

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville State</u>				c. LENGTH OF STAY IN 1b <u>1 mo., 10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				e. STREET ADDRESS <u>1541 Poplar Grove Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Carey</u> Last <u>Carey</u>				4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u>	
9. AGE (In years last birthday) yrs. <u>68?</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cafeteria Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas Carey</u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Hospital Records</u> Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hyperglycemia - Diabetic</u> <u>260x</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dehydration and Senility</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-11-</u> , 19 <u>57</u> , to <u>8-21-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-21-</u> , 19 <u>57</u> , and that death occurred at <u>12:05 a.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				DATE SIGNED <u>8-21-57</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>25 Aug, 57</u>		<u>Charlotte Co. Va</u>		<u>Charlotte Co. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lionel M. Dainwright</u>				24a. REC'D BY REGISTRAR <u>8/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

RECEIVED
JUN 26 1957
BUREAU K. I.

UG 28 1957

CERTIFICATE OF DEATH

Reg. Dist. No. 08150 27

08181

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade, Maryland	
c. LENGTH OF STAY IN 1b 11 months		d. STREET ADDRESS Hqs Co, 2nd USA Spt Elm	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROLAND Middle HOWARD Last CAREY		4. DATE OF DEATH Month Aug. Day 2 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 April 1931
9. AGE (In years last birthday) 26 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylv.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert Carey		14. MOTHER'S MAIDEN NAME Lucy Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 176-32-5672 1/2	
17. INFORMANT Fort Meade Personnel Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Drowning ? Tentative (c) Interval between pending report of autopsy		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Body found floating in Kelly Pool Ft Meade, Md on 2 Aug 57		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour ? a. m. 19 p. m. ?	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) A.A.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1915hrs-2 Aug 57 to 19 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fort George G. Meade, Md. DATE SIGNED 2 Aug 57			
ACTUAL SIGNATURE [Signature] M.D. Fort George G. Meade, Md. 2 Aug 57			
PHYSICIAN'S NAME (Type) JAMES A. CUTSHAW, Captain, MC			
22a. DATE OF BURIAL 8-6-57	22b. DATE THEREOF 8-6-57	22c. NAME OF CEMETERY Beverly National	22d. LOCATION (City, town, or county) (State) Beverly, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolverton		24a. REC'D BY REGISTRAR DATE 5 Aug 57	
24b. REGISTRAR'S SIGNATURE Wilbur H. Downs, Jr. Capt. MSC			

6306 - Belair Road , Baltimore -6, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

No inf. med Exam. 9/13/57 (By Phone ans)

AUG 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08136

CERTIFICATE OF DEATH

08151 21
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cape St. Clair, Annapolis X 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Carmino Raffaele</u> Middle <u>xxxx</u> Last <u>Cavallo</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1887</u>
9. AGE (In years last birthday) <u>69</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taylor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Naples Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. States</u>	
13. FATHER'S NAME <u>Michael Cavallo</u>		14. MOTHER'S MAIDEN NAME <u>Luigia Ratti</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>216-07-1354</u>	
17. INFORMANT <u>Son, Michael - Cape St. Clair, Md.</u>		Address <u>Annapolis</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C.V. Disease</u> (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> , 19____, to _____, 19____, that I last saw the deceased alive on <u>8-20-</u> 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Robert R. Hahn, M.D. Severna Park Md</u> <u>8-21-57.</u>			
ACTUAL SIGNATURE <u>Robert R. Hahn</u>		PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>		ADDRESS <u>322 S. High St.</u>	
24a. REC'D BY REGISTRAR <u>8/22/57</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Finch</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DURATION OF ILLNESS		DATE OF ONSET		DATE OF LAST EXAMINATION		DATE OF LAST TREATMENT		DATE OF LAST VISIT		DATE OF LAST CONTACT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF NOTARY		SIGNATURE OF WITNESS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. 1

AUG 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 20 Film 219 8-28-57 ams									
08137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 08152									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>C. C.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park, Md.</u> X2				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>					d. STREET ADDRESS <u>1</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA</u> <u>CRATES</u>					4. DATE OF DEATH Month Day Year <u>8</u> <u>9</u> <u>1957</u>				
5. SEX <u>Female</u>					6. COLOR OF RACE <u>Col</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>6-27-1911</u>				
9. AGE (In years for birthday) <u>46</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
11. BIRTHPLACE (State or foreign country) <u>A.A. Co. Md.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Summerville</u>					14. MOTHER'S MAIDEN NAME <u>Luvonia Jackson</u>				
15. WAS DECEASED EVER IN ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>-</u>				
17. INFORMANT <u>Clara Brown</u>					Address <u>Severna Park, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Subarachnoid Hemorrhage</u> <u>902.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from chair to ground striking Head</u>				
20c. TIME OF INJURY Month, Day, Year <u>about 8/8/57</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>					20f. (City or town) (County) (State) <u>Jones Station A.A. Co. Md.</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>[Signature]</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>F. L. W. [Signature]</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>8-13-57</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Carpenter's Hill</u>					22d. LOCATION (City, town, or county) (State) <u>Round Bay, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Heese, Baltimore, Md.</u>					24a. REC'D BY REGISTRAR <u>[Signature]</u>				
					24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				
					DATE <u>AUG 22 1957</u>				

12/15/1957
J. J. [illegible]
[illegible]

[illegible]
[illegible]
[illegible]

6-27-1958 44
J. J. [illegible]
[illegible]
[illegible]
[illegible]

BUREAU V. A.

AUG 22 1957

RECEIVED

8-13-57
[illegible]
[illegible]

08153
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANCO</u>	MARYLAND	STATE <u>VA</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Annapolis</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Bally</u>	83X-9
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>425 W. Main St. Bally Va.</u>	
3. NAME OF DECEASED: (Type or Print) <u>Fred</u>		(Middle) <u>NORMAN</u>	(Last) <u>Ch.lds</u>
4. DATE OF DEATH	(Month) <u>8</u>	(Day) <u>11</u>	(Year) <u>1957</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept. 18, 1927</u>
9. AGE last birthday: <u>29</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Brick Layer</u>	11. BIRTHPLACE (State or foreign country): <u>Caroline Co. Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Warren Childs</u>		14. MOTHER'S MAIDEN NAME: <u>May Elzgie Washington</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>Myrtle Childs, Bally Va.</u>

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
850X Immediate cause	(a) DUE TO	Strawberry	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <i>Shower stall</i>		21c. (City or town) (County) (State) <i>Alto</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5 11:57 AM</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Back burned over</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <i>John Lock</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>8-11-57</i> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Removal	✓	St John Church	Caroline Co. Va.	
DATE REC'D BY LOCAL REG. AUG 13 '57	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
	W. Leach	DABNEY FUNERAL HOME,	Box 528	
		Ashland Va.		

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
are is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

AUG 15 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 21

08139

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis 10			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 Monticello Ave.				f. STREET ADDRESS 104 Monticello Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle LEE Last CLARK				4. DATE OF DEATH Month August Day 31 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 18, 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper, ret				10b. KIND OF BUSINESS OR INDUSTRY Dairy Company		11. BIRTHPLACE (State or foreign country) Edgewater, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William D.K. Lee				14. MOTHER'S MAIDEN NAME Mary Larrimore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-0660		17. INFORMANT Leonard A. Clark Son Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 1 hr 1 month						INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis, Chronic							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept. 1, 1955 to Aug. 30, 1957 , that I last saw the deceased alive on 8-30-1957 , and that death occurred at 7:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Shaw Street, Annapolis, Md. DATE SIGNED 9-1-57							
ACTUAL SIGNATURE James R. Martin M.D.							
PHYSICIAN'S NAME (Type) James R. Martin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				24. REC'D BY REGISTRAR SEP 1 1957			
ADDRESS Annapolis, Md.				24b. REGISTRAR'S SIGNATURE John J. French			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. 3

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08182
CERTIFICATE OF DEATH

08155
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>4 yrs, 10 mo, 29 ds.</u>		d. STREET ADDRESS <u>101 Spring Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charlie</u> Middle <u>Coleman</u> Last <u>Coleman</u>		4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years lost birthday) <u>67 3/4</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Robert Coleman</u>		14. MOTHER'S MAIDEN NAME <u>Annie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tb. Lobar Pneumonia</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ca. Lung</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>September 18, 19 52</u> , to <u>August 16, 19 57</u> , that I last saw the deceased alive on <u>August 16, 19 57</u> , and that death occurred at <u>8:45 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Cyril G. Hardy</u>		M.D. <u>Crownsville State Hospital, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Cyril G. Hardy, M.D.</u>		M.D. <u>Crownsville State Hospital, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8-20-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. of Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md. 8/20/57</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William G. Reese, Jr. - Anna. Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>AUG 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>A. M. Jones</u>	

BUREAU V.

JUN 22 1957

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 20 Film 219 8-23-57 ams

08156

08183

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Puerto Rico</u> COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (In this place) <u>1 yr 8 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Carolina</u>		✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u> <u>U.S. ARMY HOSP FT. GEO. G. MEADE</u>				STREET ADDRESS (If rural give location) <u>158 Munez-Rivera Street</u>			
3. NAME OF DECEASED (Type or Print) <u>LUIS</u> (First) <u>M.</u> (Middle) <u>COLON-FEBRES</u> (Last) <u>LUIS M. COLON-FEBRES</u>				4. DATE OF DEATH <u>August 12</u> 19 <u>57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3 November 1935</u>	9. AGE last birthday <u>22</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Puerto Rico</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Aurilio Colon-Rivera</u>				14. MOTHER'S MAIDEN NAME <u>Julia Febres-de Colon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Personnel Records,</u> <u>Fort George G. Meade, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Multiple lacerations of left lobe, quadrate and candate lobe of liver with intra-abdominal hemorrhage. Laceration of right kidney.</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Shock</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Compound fracture of right tibia and femur.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Disney Road, Md.</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>nr. Ft. George G. Meade Prince George Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>9:40 P.M. 12 Aug 57</u> M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21f. HOW DID INJURY OCCUR? <u>Auto accident - was in front seat. was not driving</u>			
22. I hereby certify that I attended the deceased from <u>12 AUG 57</u> , to <u>12 AUG 57</u> , that I last saw the deceased alive on <u>12 AUG 57</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John L. Robertson</u>		JOHN L. ROBERTSON, Capt, MC M.D.		ADDRESS (Street, city, town, state) <u>USAH, Ft G. G. Meade, Md.</u>		DATE SIGNED <u>12 Aug 57</u>	
23. DATE THEREOF <u>AUG. 16/57</u>		NAME OF CEMETERY OR CREMATORY <u>Municipal Cemetery</u>		LOCATION (City, town, or county) (State) <u>Carolina, Puerto Rico</u>			
24. REC'D BY REGISTRAR <u>Wilbur H. Downs, Jr.</u>		REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Wolverton</u>		ADDRESS <u>Funeral Home, Inc.</u> <u>6306 Belair Road, Baltimore-6, Md, USA</u>	
DATE <u>13 Aug 57</u>							

CERTIFICATE OF DEATH

21. GRAVE AND SERVICE PHONE OF DECEASED

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH
 PLACE OF BIRTH

DATE OF DEATH
 PLACE OF DEATH
 TIME OF DEATH

CAUSE OF DEATH
 MANNER OF DEATH

EDUCATION
 OCCUPATION

PREVIOUS ILLNESS
 PRESENT ILLNESS

DIAGNOSIS
 TREATMENT

DATE OF EXAMINATION
 PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR

DATE OF BIRTH
 PLACE OF BIRTH

EDUCATION
 OCCUPATION

PREVIOUS ILLNESS
 PRESENT ILLNESS

DIAGNOSIS
 TREATMENT

DATE OF EXAMINATION
 PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR

DATE OF BIRTH
 PLACE OF BIRTH

EDUCATION
 OCCUPATION

PREVIOUS ILLNESS
 PRESENT ILLNESS

DIAGNOSIS
 TREATMENT

DATE OF EXAMINATION
 PLACE OF EXAMINATION

SIGNATURE OF PHYSICIAN
 SIGNATURE OF REGISTRAR

DATE OF BIRTH
 PLACE OF BIRTH

EDUCATION
 OCCUPATION

PREVIOUS ILLNESS
 PRESENT ILLNESS

DIAGNOSIS
 TREATMENT

BUREAU V. S.

AUG 19 1957

RECEIVED

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1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 FilmG219 8-28-57 et

CERTIFICATE OF DEATH

08157

08184

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>ALYNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Ferndale, Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1 Eugenia Ave</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>A.A. Co.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FERNDALE</u> STREET ADDRESS (If rural give location) <u>1 EUGENIA AVE.</u>											
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William CONNER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 21 1957</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Sept 7, 1892</u>		9. AGE last birthday <u>64</u> yrs.		10. UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineering Dept Bendix Radio</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>William D E Conner</u>				14. MOTHER'S MAIDEN NAME <u>Annie E Colwell</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or sunk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>213-10-8816</u>				17. INFORMANT & ADDRESS <u>Annie E Conner - Eugenia Ave</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C)				18. MEDICAL CERTIFICATION <u>Arteriosclerotic heart disease</u> <u>Coronary Thrombosis</u> <u>Diabetes Mellitus</u>								INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.															
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Feb 25 1957</u> , to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-1 1957</u> , and that death occurred at <u>2:00 P</u> M, from the causes and on the date stated above. SIGNATURE <u>Joseph Taler</u> ADDRESS (Street, city, town, state) <u>102 B&A Blvd. N.E. Glen Burnie, Md. 8-2257</u> DATE SIGNED <u>Aug 24 1957</u>															
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Aug 24 1957</u>				DATE THEREOF <u>Aug 24 1957</u>				NAME OF CEMETERY OR CREMATORY <u>Western</u>				LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
24. REC'D BY REGISTRAR <u>AUG 23 1957</u>				REGISTRAR'S SIGNATURE <u>L. J. Sullivan</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>Tom Cook Inc</u>				ADDRESS <u>1217 St Paul St</u>			

CERTIFICATE OF DEATH

For Filing

1. Usual Residence (Name of Decedent)

2. Place of Birth

3. Date of Birth

4. Sex

5. Race

6. Marital Status

7. Occupation

8. Cause of Death

9. Date of Death

10. Place of Death

11. Signature of Physician

12. Signature of Registrar

13. Signature of Coroner

14. Signature of Medical Examiner

15. Signature of Burial Officer

16. Signature of Undertaker

17. Signature of Funeral Home

18. Signature of Cemetery

19. Signature of Interment

20. Signature of Burial

21. Signature of Burial

22. Signature of Burial

23. Signature of Burial

24. Signature of Burial

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55. Signature of Burial

56. Signature of Burial

57. Signature of Burial

BUREAU M. B.

AUG 23 1957

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0815821

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A.A. Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>P. Har.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Emergency Hospital (A.A. Co.)</i>		d. STREET ADDRESS <i>9323 Fourth Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>SANDRA JEANE COOKE</i>		4. DATE OF DEATH Month Day Year <i>8 - 17 1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 14, 1943</i>
9. AGE (In years last birthday) <i>14</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>school</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D/ C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Sampson Roe Cooke</i>		14. MOTHER'S MAIDEN NAME <i>Suzanne Spindle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Suzanne Spindle</i>		Address <i>Lanham, Maryland.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>FRACURE - SKULL -</i> <i>816X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>auto accident</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>5-17 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Highway</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>A.A. Co.</i>		20f. (City or town) (County) (State) <i>A.A. Co.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <i>8-17-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 20, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Bladensburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>AUG 22 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Wm J. French</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Age: _____</p>		<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>		<p>6. Cause of death: _____</p>	
<p>7. Manner of death: _____</p>		<p>8. Signature of medical examiner: _____</p>	
<p>9. Signature of coroner: _____</p>		<p>10. Signature of physician: _____</p>	
<p>11. Signature of witness: _____</p>		<p>12. Signature of witness: _____</p>	
<p>13. Signature of witness: _____</p>		<p>14. Signature of witness: _____</p>	
<p>15. Signature of witness: _____</p>		<p>16. Signature of witness: _____</p>	
<p>17. Signature of witness: _____</p>		<p>18. Signature of witness: _____</p>	
<p>19. Signature of witness: _____</p>		<p>20. Signature of witness: _____</p>	
<p>21. Signature of witness: _____</p>		<p>22. Signature of witness: _____</p>	
<p>23. Signature of witness: _____</p>		<p>24. Signature of witness: _____</p>	
<p>25. Signature of witness: _____</p>		<p>26. Signature of witness: _____</p>	
<p>27. Signature of witness: _____</p>		<p>28. Signature of witness: _____</p>	
<p>29. Signature of witness: _____</p>		<p>30. Signature of witness: _____</p>	
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<p>77. Signature of witness: _____</p>		<p>78. Signature of witness: _____</p>	
<p>79. Signature of witness: _____</p>		<p>80. Signature of witness: _____</p>	
<p>81. Signature of witness: _____</p>		<p>82. Signature of witness: _____</p>	
<p>83. Signature of witness: _____</p>		<p>84. Signature of witness: _____</p>	
<p>85. Signature of witness: _____</p>		<p>86. Signature of witness: _____</p>	
<p>87. Signature of witness: _____</p>		<p>88. Signature of witness: _____</p>	
<p>89. Signature of witness: _____</p>		<p>90. Signature of witness: _____</p>	
<p>91. Signature of witness: _____</p>		<p>92. Signature of witness: _____</p>	
<p>93. Signature of witness: _____</p>		<p>94. Signature of witness: _____</p>	
<p>95. Signature of witness: _____</p>		<p>96. Signature of witness: _____</p>	
<p>97. Signature of witness: _____</p>		<p>98. Signature of witness: _____</p>	
<p>99. Signature of witness: _____</p>		<p>100. Signature of witness: _____</p>	

BUREAU V. 1

JUG 22 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08159 *gh*

08185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>				c. LENGTH OF STAY IN TB <u>6yrs. 4mo. 13da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				e. STREET ADDRESS <u>1916 Aisquith Street</u>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Floyd</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September, 1915</u>	
9. AGE (In years lost birthday) yrs. <u>42</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>*****</u>				14. MOTHER'S MAIDEN NAME <u>Foster Mother - Daisy Sheffield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Staphylococci Infection</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>---</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>025X</u> <u>General Paresis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-23-</u> , 1957, to <u>8-25</u> , 1957, that I last saw the deceased alive on <u>8-25</u> , 1957, and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>8-26-57</u>			
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>8-27-57</u>		<u>Imperial City Md.</u>		<u>Balt. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kneese</u>				24a. REC'D BY REGISTRAR <u>8/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Jeyar</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH		6. DATE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH	
JAMES EARL RAY		MALE		35		WHITE		MEMPHIS, TENN.		MAY 1, 1928		MEMPHIS, TENN.		APRIL 4, 1968	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. PLACE OF INTERMENT		13. NAME OF FUNERAL HOME		14. NAME OF MINISTER		15. NAME OF CLERGYMAN		16. NAME OF CHURCH	
CONGRESSMAN		SHOOTING		HOMICIDE		MEMPHIS, TENN.		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESS		19. SIGNATURE OF MINISTER		20. SIGNATURE OF CLERGYMAN		21. SIGNATURE OF CHURCH		22. SIGNATURE OF FUNERAL HOME		23. SIGNATURE OF MINISTER		24. SIGNATURE OF CLERGYMAN	

BUREAU K. 1

AUG 29 1967

RECEIVED

Reg. Dist. No.

08186

8/9/57

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		HEART DISEASE		NATURAL	
PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		AUG 6 1968		10 00 PM		10 00		00	
PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT		COUNTRY OF INTERMENT		DATE OF INTERMENT		TIME OF INTERMENT		HOURS OF INTERMENT		MINUTES OF INTERMENT	
BALTIMORE		BALTIMORE		MARYLAND		UNITED STATES		AUG 13 1968		10 00 AM		10 00		00	
NAME OF PHYSICIAN		NAME OF NURSE		NAME OF CLERK		NAME OF CHURCH		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF MONUMENT	
DR. JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS		NAME OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

AUG 13 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08161

08141

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sudley x1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. General</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>LIDA ANNE</i> First Middle Last <i>Candall</i>		4. DATE OF DEATH <i>Aug 9</i> Month Day Year <i>3 1957</i>	
5. SEX <i>White</i>	6. COLOR OR RACE <i>Female</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 14 1865</i>
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MD</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>WM. KEMP DAWSON</i>		14. MOTHER'S MAIDEN NAME <i>MARGARET REBECCA SIMMONS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT Address <i>LIDA MORELAND LOTHIAN MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular accident cerebral</i> <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i>chronic nephritis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 10</i> , 1957, to <i>August 3</i> , 1957, that I last saw the deceased alive on <i>August 3</i> , 1957, and that death occurred at <i>1230</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D. <i>Lothian, Md</i> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/5/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Truher</i>		22d. LOCATION (City, town, or county) (State) <i>Galesville Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Arduty</i>		24a. REC'D BY REGISTRAR <i>Galesville Md</i>	
24b. REGISTRAR'S SIGNATURE <i>10-10-57</i>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

02-41

02161

PLACE IN SPACE FOR PHOTOGRAPH		MARRIAGE	
1. DATE OF DEATH		2. TIME OF DEATH	
3. PLACE OF DEATH		4. CAUSE OF DEATH	
5. MANNER OF DEATH		6. SEX	
7. AGE		8. RACE	
9. BIRTH DATE		10. BIRTH PLACE	
11. OCCUPATION		12. EDUCATION	
13. MARITAL STATUS		14. PREVIOUS MARRIAGES	
15. DATE OF MARRIAGE		16. NAME OF SPOUSE	
17. NAME OF DECEASED		18. NAME OF FATHER	
19. NAME OF MOTHER		20. NAME OF SISTER	
21. NAME OF BROTHER		22. NAME OF NEPHEW	
23. NAME OF UNCLE		24. NAME OF AUNT	
25. NAME OF GRANDFATHER		26. NAME OF GRANDMOTHER	
27. NAME OF GREAT-GRANDFATHER		28. NAME OF GREAT-GRANDMOTHER	
29. NAME OF GREAT-GRANDFATHER		30. NAME OF GREAT-GRANDMOTHER	
31. NAME OF GREAT-GRANDFATHER		32. NAME OF GREAT-GRANDMOTHER	
33. NAME OF GREAT-GRANDFATHER		34. NAME OF GREAT-GRANDMOTHER	
35. NAME OF GREAT-GRANDFATHER		36. NAME OF GREAT-GRANDMOTHER	
37. NAME OF GREAT-GRANDFATHER		38. NAME OF GREAT-GRANDMOTHER	
39. NAME OF GREAT-GRANDFATHER		40. NAME OF GREAT-GRANDMOTHER	
41. NAME OF GREAT-GRANDFATHER		42. NAME OF GREAT-GRANDMOTHER	
43. NAME OF GREAT-GRANDFATHER		44. NAME OF GREAT-GRANDMOTHER	
45. NAME OF GREAT-GRANDFATHER		46. NAME OF GREAT-GRANDMOTHER	
47. NAME OF GREAT-GRANDFATHER		48. NAME OF GREAT-GRANDMOTHER	
49. NAME OF GREAT-GRANDFATHER		50. NAME OF GREAT-GRANDMOTHER	
51. NAME OF GREAT-GRANDFATHER		52. NAME OF GREAT-GRANDMOTHER	
53. NAME OF GREAT-GRANDFATHER		54. NAME OF GREAT-GRANDMOTHER	
55. NAME OF GREAT-GRANDFATHER		56. NAME OF GREAT-GRANDMOTHER	
57. NAME OF GREAT-GRANDFATHER		58. NAME OF GREAT-GRANDMOTHER	
59. NAME OF GREAT-GRANDFATHER		60. NAME OF GREAT-GRANDMOTHER	
61. NAME OF GREAT-GRANDFATHER		62. NAME OF GREAT-GRANDMOTHER	
63. NAME OF GREAT-GRANDFATHER		64. NAME OF GREAT-GRANDMOTHER	
65. NAME OF GREAT-GRANDFATHER		66. NAME OF GREAT-GRANDMOTHER	
67. NAME OF GREAT-GRANDFATHER		68. NAME OF GREAT-GRANDMOTHER	
69. NAME OF GREAT-GRANDFATHER		70. NAME OF GREAT-GRANDMOTHER	
71. NAME OF GREAT-GRANDFATHER		72. NAME OF GREAT-GRANDMOTHER	
73. NAME OF GREAT-GRANDFATHER		74. NAME OF GREAT-GRANDMOTHER	
75. NAME OF GREAT-GRANDFATHER		76. NAME OF GREAT-GRANDMOTHER	
77. NAME OF GREAT-GRANDFATHER		78. NAME OF GREAT-GRANDMOTHER	
79. NAME OF GREAT-GRANDFATHER		80. NAME OF GREAT-GRANDMOTHER	
81. NAME OF GREAT-GRANDFATHER		82. NAME OF GREAT-GRANDMOTHER	
83. NAME OF GREAT-GRANDFATHER		84. NAME OF GREAT-GRANDMOTHER	
85. NAME OF GREAT-GRANDFATHER		86. NAME OF GREAT-GRANDMOTHER	
87. NAME OF GREAT-GRANDFATHER		88. NAME OF GREAT-GRANDMOTHER	
89. NAME OF GREAT-GRANDFATHER		90. NAME OF GREAT-GRANDMOTHER	
91. NAME OF GREAT-GRANDFATHER		92. NAME OF GREAT-GRANDMOTHER	
93. NAME OF GREAT-GRANDFATHER		94. NAME OF GREAT-GRANDMOTHER	
95. NAME OF GREAT-GRANDFATHER		96. NAME OF GREAT-GRANDMOTHER	
97. NAME OF GREAT-GRANDFATHER		98. NAME OF GREAT-GRANDMOTHER	
99. NAME OF GREAT-GRANDFATHER		100. NAME OF GREAT-GRANDMOTHER	

BUREAU V. 1

JUG 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08162

Reg. Dist. No.

21

08142

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x 2 RFD Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Best Gate Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Grady Dillion Jr.</u>				4. DATE OF DEATH Month Day Year <u>August 14 19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 12, 1957</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Welch, West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Grady Dillion</u>				14. MOTHER'S MAIDEN NAME <u>Josephine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Mr William G. Dillion</u>				Address <u>Father same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>921.0</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO (c) <u>Stroke</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Aspiration Vomitus</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Lawrence NE Best Gate AA Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>8/14/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Patuxent, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24a. REC'D BY REGISTRAR <u>Aug 19 1957</u>			
ADDRESS <u>Annapolis, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>M. J. Sherah</u>			

MEDICAL CERTIFICATION

02

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08163
 Reg. Dist. No. 21

08143

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle S Last DONALDSON				4. DATE OF DEATH Month 8th Day 16th Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 20, 1879		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Street Car Driver				10b. KIND OF BUSINESS OR INDUSTRY Streets Cars		11. BIRTHPLACE (State or foreign country) Washington D.C.	
13. FATHER'S NAME Thomas S. Donaldson				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME Mary E.				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Raymond A. Evans Address 2423 Kenton Place			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive failure Cardiovascular DUE TO (c) 14 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old coronary occlusion (b) 14 days (c) 14 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from August 13, 1957 , to August 16, 1957 , that I last saw the deceased alive on August 16, 1957 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Franklin D. Hendricks M.D.				ADDRESS (Street, city or town, state) Shady Side, Maryland			
DATE SIGNED 8/17/57							
PHYSICIAN'S NAME (Type) Franklin D. Hendricks MD							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-20-57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sam Lee & Sons				ADDRESS 3004 4th St. Baltimore		24a. REC'D BY REGISTRAR DATE AUG 18 1957	
24b. REGISTRAR'S SIGNATURE M. J. French							

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of coroner		12. Signature of undertaker	
13. Signature of funeral home		14. Signature of cemetery		15. Signature of burial place	
16. Signature of interment place		17. Signature of burial place		18. Signature of burial place	
19. Signature of burial place		20. Signature of burial place		21. Signature of burial place	
22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place	
28. Signature of burial place		29. Signature of burial place		30. Signature of burial place	
31. Signature of burial place		32. Signature of burial place		33. Signature of burial place	
34. Signature of burial place		35. Signature of burial place		36. Signature of burial place	
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49. Signature of burial place		50. Signature of burial place		51. Signature of burial place	
52. Signature of burial place		53. Signature of burial place		54. Signature of burial place	
55. Signature of burial place		56. Signature of burial place		57. Signature of burial place	
58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place	
64. Signature of burial place		65. Signature of burial place		66. Signature of burial place	
67. Signature of burial place		68. Signature of burial place		69. Signature of burial place	
70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place	
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79. Signature of burial place		80. Signature of burial place		81. Signature of burial place	
82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
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91. Signature of burial place		92. Signature of burial place		93. Signature of burial place	
94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place	
100. Signature of burial place		101. Signature of burial place		102. Signature of burial place	

BUREAU V. 2

AUG 19 1957

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08187

CERTIFICATE OF DEATH

08164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.				c. LENGTH OF STAY IN 1b 3 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				d. STREET ADDRESS 617 N. Mount Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anita Middle Downs Last Downs				4. DATE OF DEATH Month 8 Day 2 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/1917	
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 4		IF UNDER 24 HRS. Hours 40 Min. 4			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME Joshua Downs				14. MOTHER'S MAIDEN NAME Susan Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 0		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Hospital Records Address Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Schizophrenia, Paranoid Type DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, Paranoid Type							INTERVAL BETWEEN ONSET AND DEATH 7/30/57
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. 8/2 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from Oct. 27 , 19 54 , to August 2 , 19 57 , that I last saw the deceased alive on 8/2 , 19 57 , and that death occurred at 9:55 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Cornwell Newton, M.D.				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 8/2/57	
PHYSICIAN'S NAME (Type) Cornwell Newton, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 8/8/57		22c. NAME OF CEMETERY OR CREMATORY Mt Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hays				ADDRESS Baltimore Md		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE A. M. Joyce							

CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Date of birth: <i>Jan 1, 1900</i></p>		<p>4. Place of birth: <i>Johns Hopkins</i></p>	
<p>5. Date of death: <i>Aug 5, 1957</i></p>		<p>6. Place of death: <i>Johns Hopkins</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Manner of death: <i>Natural</i></p>	
<p>9. Signature of physician: <i>John Doe</i></p>		<p>10. Signature of registrar: <i>John Doe</i></p>	
<p>11. Signature of family: <i>John Doe</i></p>		<p>12. Signature of hospital: <i>Johns Hopkins</i></p>	
<p>13. Signature of coroner: <i>John Doe</i></p>		<p>14. Signature of funeral home: <i>John Doe</i></p>	
<p>15. Signature of cemetery: <i>John Doe</i></p>		<p>16. Signature of burial place: <i>John Doe</i></p>	
<p>17. Signature of interment: <i>John Doe</i></p>		<p>18. Signature of cremation: <i>John Doe</i></p>	
<p>19. Signature of other: <i>John Doe</i></p>		<p>20. Signature of other: <i>John Doe</i></p>	

BUREAU V. B.
AUG 7 1957

RECEIVED

BUREAU V. B.

John Doe
John Doe

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08188
CERTIFICATE OF DEATH

08165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. Meade Ft Meade</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cincinnati, Ohio 72 x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ft. Meade U.S. ARMY HOSPITAL</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>KENNETH WAYNE Boy DeChemin</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 Aug 57 '57</u>
9. AGE (In years last birthday) <u>2 days</u>		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>1</u> Days <u>13</u> Hours <u>25</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT RAY DUCHEMIN Robert DeChemin</u>		14. MOTHER'S MAIDEN NAME <u>JUDITH BETH PITZER Judy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records U.S. Army Hosp, Ft Meade, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day 13 hrs 25 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>29 August</u> , 19 <u>57</u> , and that death occurred at <u>0402</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE _____ M.D. <u>C. E. Lacoste Capt MC</u> <u>29 Aug 57</u> PHYSICIAN'S NAME (Type) <u>C. E. LACOSTE, CAPT, MC</u> <u>U. S. ARMY HOSPITAL, Ft G. G. Meade, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-30-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. COOK, Inc., 1217 St. Paul Street</u>		24. REC'D BY REGISTRAR DATE <u>29 Aug 57</u> <u>Wm. A. Kelly Jr.</u> PL. MSC	

2150191XV0

RECEIVED

AUG 30 1957

BUREAU V. S.

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C. 20535	
DATE OF BIRTH: 1910-01-01		DATE OF DEATH: 1957-08-20	
PLACE OF BIRTH: [illegible]		PLACE OF DEATH: [illegible]	
MARRIAGE: [illegible]		CAUSE OF DEATH: [illegible]	
EDUCATION: [illegible]		OCCUPATION: [illegible]	
RELIGION: [illegible]		POLITICAL AFFILIATION: [illegible]	
MILITARY SERVICE: [illegible]		NATIONALITY: [illegible]	
MARITAL STATUS: [illegible]		SEX: [illegible]	
HEIGHT: [illegible]		WEIGHT: [illegible]	
HAIR: [illegible]		EYES: [illegible]	
SKIN: [illegible]		BUILD: [illegible]	
TATTOOS: [illegible]		SCARS: [illegible]	
FINGERPRINTS: [illegible]		TOOTH MARKS: [illegible]	
DNA: [illegible]		HAIR ANALYSIS: [illegible]	
BLOOD: [illegible]		SWEAT: [illegible]	
TEARS: [illegible]		URINE: [illegible]	
FECES: [illegible]		OTHER: [illegible]	

08189

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Fort George G. Meade Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ohio</u> b. COUNTY <u>Hamilton</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>		c. LENGTH OF STAY IN 1b <u>15 hrs 30 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fort George G. Meade U. S. Army Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KEITH</u> First <u>WESLEY</u> Middle <u>DUCHEMIN</u> Last <u>DeChemin</u> Infant <u>B</u>		4. DATE OF DEATH Month <u>August</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 27, 1957</u> <u>27-Aug-57</u>
9. AGE (In years, last birthday) yrs. <u>15</u> Months <u>3</u> Days <u>30</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Ray DuChemin</u> <u>DeChemin, Robert</u>		14. MOTHER'S MAIDEN NAME <u>Judith Beth Pitzer</u> <u>DeChemin, Judy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother, Route #1, Box 160, Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs 30 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>27 Aug 57</u> to <u>28 Aug 57</u> , that I last saw the deceased alive on <u>27 Aug 57</u> , and that death occurred at <u>7:10</u> M, from the causes and on the date stated above. DATE SIGNED <u>28 Aug 57</u>			
ACTUAL SIGNATURE <u>Arnold Fiascone</u>		M.D. <u>USAH Ft Geo. G. Meade</u>	
PHYSICIAN'S NAME (Type) <u>ARNOLD FIASCONE, Capt, MC, USAH, Ft Geo. G. Meade, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-29-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1218 St. Paul Street</u>		24. REC'D BY REGISTRAR DATE <u>28 Aug 57</u>	
		25. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MBE</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2250192XVO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE

TIME

PLACE

TIME

CAUSE OF DEATH

CAUSE OF DEATH

DATE

TIME

BUREAU V. 4

AUG 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
08190					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					08167				
										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>B. A.</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>1</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>James S. Duvall</u>					4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1957</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-2-1902</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Thomas Duvall</u>					14. MOTHER'S MAIDEN NAME <u>Allice Randall</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Leon Duvall - Harwood, Md.</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>4343</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u> </u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>8-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>			22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beebe - Annapolis, Md.</u>					ADDRESS		24a. REC'D BY REGISTRAR <u>AUG 22 '57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beebe</u>					

AUG 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL CERTIFICATION

08191				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				08168			
				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				Reg. Dist. No.			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>				c. LENGTH OF STAY IN 1b <u>15 minutes</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Stoney Creek</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>				b. COUNTY <u>Anne Arundel</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ferdinand Nicholas Ellinghaus</u>				4. DATE OF DEATH Month Day Year <u>August 10th 1957 19</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/6/1902</u>		9. AGE (In years last birthday) <u>54 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Henry Ellinghaus</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Schaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>218-07-2280</u>				17. INFORMANT Address <u>Mr. Nicholas Henry Ellinghaus (brother)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> <u>850x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was crabbing and fell of his row boat in Sotney Creek.</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>6.30 P. m.</u> <u>8/10/57</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stoney Creek</u>			
20f. (City or town) <u>Pasadena, A.A.</u>				20g. (County) <u>Md.</u>				20h. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8/14/57</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Baltimore</u>				22e. (State) <u>Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>				23a. REC'D BY REGISTRAR <u>AUG 13 1957</u>				23b. REGISTRAR'S SIGNATURE <u>L. J. Sedberry</u>			
23c. ADDRESS <u>Balto. Md.</u>				23d. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				23e. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
23f. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/10/57</u>											

1910

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, cause of death, and signature.

BUREAU V. S.

AUG 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G219 8-29-57 et

CERTIFICATE OF DEATH

08192

08169

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>No Home</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Evans</u> Last <u>Evans</u>		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/25/1883</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>73</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Evans</u>		14. MOTHER'S MAIDEN NAME <u>Cathryn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>-----</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Known to us</u> <u>since 5/10/51</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>-----</u> 19 <u>57</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>		20f. (City or town) (County) (State) <u>-----</u>	
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>57</u> , to <u>8/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 21</u> , 19 <u>57</u> , and that death occurred at <u>11:40a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Crowned Newton, M.D.</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>AUG-24-57</u>		22b. DATE THEREOF <u>Aug 24 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>W. H. Anderson</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Harnely</u>		24a. REC'D BY REGISTRAR <u>578 W. 13th St.</u>	
24b. REGISTRAR'S SIGNATURE <u>K. M. Joyce</u>		DATE <u>8/23/57</u>	

RECEIVED

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. RACE <i>WHITE</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. DATE OF BIRTH <i>1912</i>		7. PLACE OF DEATH <i>BALTIMORE</i>		8. DATE OF DEATH <i>AUG 18 1957</i>	
9. OCCUPATION <i>CLERK</i>		10. CAUSE OF DEATH <i>HEART DISEASE</i>		11. MANNER OF DEATH <i>NATURAL</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF DECEASED <i>[Signature]</i>		16. SIGNATURE OF WITNESS <i>[Signature]</i>	
17. SIGNATURE OF DECEASED <i>[Signature]</i>		18. SIGNATURE OF WITNESS <i>[Signature]</i>		19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF WITNESS <i>[Signature]</i>	
21. SIGNATURE OF DECEASED <i>[Signature]</i>		22. SIGNATURE OF WITNESS <i>[Signature]</i>		23. SIGNATURE OF DECEASED <i>[Signature]</i>		24. SIGNATURE OF WITNESS <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF WITNESS <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>		28. SIGNATURE OF WITNESS <i>[Signature]</i>	
29. SIGNATURE OF DECEASED <i>[Signature]</i>		30. SIGNATURE OF WITNESS <i>[Signature]</i>		31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF WITNESS <i>[Signature]</i>	
33. SIGNATURE OF DECEASED <i>[Signature]</i>		34. SIGNATURE OF WITNESS <i>[Signature]</i>		35. SIGNATURE OF DECEASED <i>[Signature]</i>		36. SIGNATURE OF WITNESS <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF WITNESS <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>		40. SIGNATURE OF WITNESS <i>[Signature]</i>	
41. SIGNATURE OF DECEASED <i>[Signature]</i>		42. SIGNATURE OF WITNESS <i>[Signature]</i>		43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF WITNESS <i>[Signature]</i>	
45. SIGNATURE OF DECEASED <i>[Signature]</i>		46. SIGNATURE OF WITNESS <i>[Signature]</i>		47. SIGNATURE OF DECEASED <i>[Signature]</i>		48. SIGNATURE OF WITNESS <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF WITNESS <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>		52. SIGNATURE OF WITNESS <i>[Signature]</i>	
53. SIGNATURE OF DECEASED <i>[Signature]</i>		54. SIGNATURE OF WITNESS <i>[Signature]</i>		55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF WITNESS <i>[Signature]</i>	
57. SIGNATURE OF DECEASED <i>[Signature]</i>		58. SIGNATURE OF WITNESS <i>[Signature]</i>		59. SIGNATURE OF DECEASED <i>[Signature]</i>		60. SIGNATURE OF WITNESS <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF WITNESS <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>		64. SIGNATURE OF WITNESS <i>[Signature]</i>	
65. SIGNATURE OF DECEASED <i>[Signature]</i>		66. SIGNATURE OF WITNESS <i>[Signature]</i>		67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF WITNESS <i>[Signature]</i>	
69. SIGNATURE OF DECEASED <i>[Signature]</i>		70. SIGNATURE OF WITNESS <i>[Signature]</i>		71. SIGNATURE OF DECEASED <i>[Signature]</i>		72. SIGNATURE OF WITNESS <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF WITNESS <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>		76. SIGNATURE OF WITNESS <i>[Signature]</i>	
77. SIGNATURE OF DECEASED <i>[Signature]</i>		78. SIGNATURE OF WITNESS <i>[Signature]</i>		79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF WITNESS <i>[Signature]</i>	
81. SIGNATURE OF DECEASED <i>[Signature]</i>		82. SIGNATURE OF WITNESS <i>[Signature]</i>		83. SIGNATURE OF DECEASED <i>[Signature]</i>		84. SIGNATURE OF WITNESS <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF WITNESS <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>		88. SIGNATURE OF WITNESS <i>[Signature]</i>	
89. SIGNATURE OF DECEASED <i>[Signature]</i>		90. SIGNATURE OF WITNESS <i>[Signature]</i>		91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF WITNESS <i>[Signature]</i>	
93. SIGNATURE OF DECEASED <i>[Signature]</i>		94. SIGNATURE OF WITNESS <i>[Signature]</i>		95. SIGNATURE OF DECEASED <i>[Signature]</i>		96. SIGNATURE OF WITNESS <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF WITNESS <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>		100. SIGNATURE OF WITNESS <i>[Signature]</i>	

BUREAU V. S.

AUG 19 1957

RECEIVED

08144

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park X0</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General Hosp.</u>				d. STREET ADDRESS <u>Gordon Ave., Route 1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>DENIS</u> Middle <u>VICTOR</u> Last <u>FORNOFF</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1957</u>		9. AGE (In years last birthday) yrs. <u>8</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>George I. Fornoff</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Denis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. George I. Fornoff - Gordon Ave., Route 1</u>		Address <u>Severna Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Aug 17</u> , 19 <u>57</u> , to <u>Aug 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. <u>Thos H. Lewis, M.D.</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/28/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tinkney</u>				24. REC'D BY REGISTRAR DATE <u>27 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thos J. Shands</u>	

2163433XVI

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		M		35		12-1-28		MOBILE, ALABAMA		LABORER		SINGLE		WHITE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
6-1-68		10:00 PM		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		J. H. [Signature]		[Signature]		[Signature]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. DISTRICT		22. WARD		23. BLOCK		24. LOT	
DAKOTA		SIOUX FALLS		SOUTH DAKOTA		57105		1		1		1		1	

BUREAU V. 2

AUG 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08194 CERTIFICATE OF DEATH

08172

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>M</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay</u>				c. LENGTH OF STAY IN 1b <u>Yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Laurel Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Gardner</u>				4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14, 1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Maintenance</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Fred Gardner</u>	
14. MOTHER'S MAIDEN NAME <u>Lyda Fanning</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214 03 2501</u>		17. INFORMANT <u>Mrs. Nelle Gardner</u> Address <u>Laurel Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Prostate & Left Kidney</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>MAY 1, 1957 (3 months)</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March, 1956</u> , to <u>August 10, 1957</u> , that I last saw the deceased alive on <u>August 9, 1957</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis I. Codd</u> ADDRESS (Street, city or town, state) <u>Severna Park, Md.</u> DATE SIGNED <u>8/10/57</u>							
PHYSICIAN'S NAME (Type) <u>Francis I. Codd M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>8/13/57</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Jefferson Mem. Cen.</u>							
22d. LOCATION (City, town, or county) (State) <u>McKeesport, Pa.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u> ADDRESS <u>130 E Fort Ave. # 30</u>							
24a. REC'D BY REGISTRAR <u>AUG 12 1957</u>							
24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>							

CERTIFICATE OF DEATH

RECEIVED
AUG 12 1957
BUREAU Y. S.

THIS IS A PERMANENT RECORD. DO NOT USE A BALL POINT PEN.

PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Physicians: please write the causes of death clearly and legibly.

I



08195

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12673 CERTIFICATE OF DEATH

081732

Reg. Dist. No.

1. NAME OF DECEASED
(Type or Print)

James Garrett

2. DATE
OF
DEATH

Aug 6, 1957

3. PLACE OF DEATH:

A. Baltimore City, Maryland 5908 Bellegrove Rd.

B. FULL NAME OF (If not in hospital or institution, give street address or location)
HOSPITAL OR INSTITUTE Anne Arundel Co.

4. USUAL RESIDENCE (Where deceased lived, If institution: residence

A. STATE B. COUNTY before admission)

5908 Bellegrove Rd A.A. Co. Md

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Patuxent Park Anne Arundel Co. Md

D. STREET ADDRESS (If rural, give location)

XO

c. Length of stay in Baltimore

51 yrs

Yrs.
Mos.
Days

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Dec 7, 1905

9. AGE (In years

last birthday)

51

10. Under 1 Year

Months: Days

11. Under 24 Hours

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Walter Garrett

14. MOTHER'S MAIDEN NAME

Mary Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Lorraine Smith 5908 Bellegrove Rd.

18.

163 X I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

CARCINOMA OF LUNG

DUE TO

ANTECEDENT CAUSES

(B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21D. TIME (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

OF INJURY

m.

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from 5/1/1957 to 8/6/1957, that (I) (we) last saw the deceased alive on 8/13/1957, and that death occurred at 6:30 pm, from the causes and on the date stated above.

23A. SIGNATURE

M.D.

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☒MED. DIRECTOR ☐STAFF PHYS. ☐

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

August 10/1957

R. W. [Signature]

Mrs. Kate R. Williams Schroeder

RECEIVED
AUG 13 1957
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08174

Reg. Dist. No. 21

08145

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place) <u>6 weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bladensburg, Md.</u>		<u>16332</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convalescent Home</u> <u>1312 West Street</u>				STREET ADDRESS (If rural give location) <u>4103--51st Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>FANNIE</u> <u>WHEELER</u> <u>HAMMOND</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>August 11th</u> , 19 <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 27th, 1871</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Adamstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wellington Hammond</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Hilleary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Wellington H. Shreve</u> <u>4103--51st St. Bladensburg, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>491x</u>				<u>BRONCHOPNEUMONIA</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>GENERAL DEBILITATION</u>				<u>3 mos</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>SEVERITY</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/25</u> , 19 <u>57</u> , to <u>8/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>57</u> , and that death occurred at <u>7:20 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Edward S. Beck</u>				ADDRESS (Street, city, town, state) <u>4150thgate AVE ANNAPOLIS MD</u>		DATE SIGNED <u>8/11/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8/14/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Frederick, Md.</u>	
24. REC'D BY REGISTRAR <u>AUG 15 1957</u>		REGISTRAR'S SIGNATURE <u>Wm J. Hendry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., Riverdale, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

Form No. 10

2142

1. NAME OF DECEASED

JOHN J. JAMES

2. SEX

Male

3. AGE

65

4. DATE OF BIRTH

1890

5. PLACE OF BIRTH

St. Louis, Mo.

6. OCCUPATION

Engineer

7. CAUSE OF DEATH

Heart Disease

8. PLACE OF DEATH

Home

9. DATE OF DEATH

Aug 15 1957

10. SIGNATURE OF PHYSICIAN

[Signature]

11. SIGNATURE OF REGISTRAR

[Signature]

12. SIGNATURE OF WITNESSES

[Signatures]

13. SIGNATURE OF DECEASED

[Signature]

14. SIGNATURE OF NEAREST RELATIVE

[Signature]

15. SIGNATURE OF CLERK

[Signature]

16. SIGNATURE OF DECEASED

[Signature]

17. SIGNATURE OF NEAREST RELATIVE

[Signature]

18. SIGNATURE OF CLERK

[Signature]

19. SIGNATURE OF DECEASED

[Signature]

20. SIGNATURE OF NEAREST RELATIVE

[Signature]

21. SIGNATURE OF CLERK

[Signature]

22. SIGNATURE OF DECEASED

[Signature]

23. SIGNATURE OF NEAREST RELATIVE

[Signature]

24. SIGNATURE OF CLERK

[Signature]

25. SIGNATURE OF DECEASED

[Signature]

26. SIGNATURE OF NEAREST RELATIVE

[Signature]

27. SIGNATURE OF CLERK

[Signature]

28. SIGNATURE OF DECEASED

[Signature]

29. SIGNATURE OF NEAREST RELATIVE

[Signature]

30. SIGNATURE OF CLERK

[Signature]

31. SIGNATURE OF DECEASED

[Signature]

32. SIGNATURE OF NEAREST RELATIVE

[Signature]

33. SIGNATURE OF CLERK

[Signature]

34. SIGNATURE OF DECEASED

[Signature]

35. SIGNATURE OF NEAREST RELATIVE

[Signature]

EXHIBIT 100-1

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. DATE OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF DECEASED
14. SIGNATURE OF NEAREST RELATIVE
15. SIGNATURE OF CLERK
16. SIGNATURE OF DECEASED
17. SIGNATURE OF NEAREST RELATIVE
18. SIGNATURE OF CLERK
19. SIGNATURE OF DECEASED
20. SIGNATURE OF NEAREST RELATIVE
21. SIGNATURE OF CLERK
22. SIGNATURE OF DECEASED
23. SIGNATURE OF NEAREST RELATIVE
24. SIGNATURE OF CLERK
25. SIGNATURE OF DECEASED
26. SIGNATURE OF NEAREST RELATIVE
27. SIGNATURE OF CLERK
28. SIGNATURE OF DECEASED
29. SIGNATURE OF NEAREST RELATIVE
30. SIGNATURE OF CLERK
31. SIGNATURE OF DECEASED
32. SIGNATURE OF NEAREST RELATIVE
33. SIGNATURE OF CLERK
34. SIGNATURE OF DECEASED
35. SIGNATURE OF NEAREST RELATIVE

BUREAU V. 2

AUG 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

081754

Reg. Dist. No.

08196

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park c. LENGTH OF STAY IN 1b Few seconds d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Annapolis Road				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same x2 d. STREET ADDRESS 203 Old Annapolis Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frederick Gustave Henkel, IV First Middle Last				4. DATE OF DEATH August 12th. 19 57 Month Day Year			
5. SEX M. 6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/ 1/25/43 yrs.		9. AGE (In years last birthday) 14 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attending school 10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frederick Gustave Henkel				14. MOTHER'S MAIDEN NAME Martha McGlannan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. F.G. Henkel (mother) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (c), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Crushed skull, neck and chest. Fractures of both arms. DUE TO (b) 812x Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was hit by an automobile and thrown in the path of a truck.					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 3.08 p. m. 8/12/57 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Old Annapolis Rd.		20f. (City or town) Severna Park, (County) A.A. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i> EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/12/57			DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/57		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Newsom</i> ADDRESS 805 N. Calvert St.				24a. REC'D BY REGISTRAR AUG 14 1957		24b. REGISTRAR'S SIGNATURE <i>L. J. Sedberry</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

SEP 5 '57

BUREAU V. S.

AUG 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08197

Items 1,2 Film 220 9-13-57 et

CERTIFICATE OF DEATH

08176

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>Ella A. Houlton</u>				4. DATE OF DEATH <u>31 August 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>19 Nov 1858</u>	9. AGE (In years last birthday) <u>98</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Edward L. Houlton</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Address</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tachycardia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive failure</u> DUE TO (c) <u>Cerebral vascular accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>31 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>31 August</u> , 19 <u>57</u> , and that death occurred at <u>4:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F.D. Hendricks</u> M.D.				ADDRESS (Street, city or town, state) <u>Shady Side, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>F.D. Hendricks</u>				DATE SIGNED <u>8-31-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9-3-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Switzland, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - DC</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Overman</u>
				DATE <u>SEP 4 '57</u>			

BUREAU V. B.

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08198

CERTIFICATE OF DEATH

Reg. Dist. No.

081724

1. PLACE OF DEATH o. COUNTY Annie Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Annie Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenburnie				c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookland, A.A.Co. Maryland X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6205 Flamingo Drive				d. STREET ADDRESS 6205 Flamingo Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle E. Last Howard				4. DATE OF DEATH Month August Day 13 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 13, 1905		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector		10b. KIND OF BUSINESS OR INDUSTRY Industrial Plant		11. BIRTHPLACE (State or foreign country) Maryland; Annie Arundel Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solan Howard				14. MOTHER'S MAIDEN NAME Ida Howard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Ida Howard		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of I Tract 159x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2-3 Months						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 57 , to Aug 13 , 19 57 , that I last saw the deceased alive on Aug 13 , 19 57 , and that death occurred at 12⁰⁰ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John M Jones Jr				ADDRESS (Street, city or town, state) 1532 Monument St Baltimore Md		DATE SIGNED Aug 13 1957	
PHYSICIAN'S NAME (Type or print) Elroy C. Wilson							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 16, 1957		22c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Brookland, A.A.Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy C. Wilson				24a. REC'D BY REGISTRAR Aug 19 1957		24b. REGISTRAR'S SIGNATURE L. J. Dealy	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral home. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08178
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton</u> X2		d. STREET ADDRESS <u>Patuxant Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Patuxant Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EVA</u> Middle <u>JANE</u> Last <u>JANUARY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1928</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months <u>28</u> Days <u>28</u> Hours <u>28</u> Min. <u>28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.A.</u>	
13. FATHER'S NAME <u>(unknown)</u> <u>Hall</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mr. John M. January</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull due to self inflicted wound</u> <u>976 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>a 22 gauge rifle.</u> DUE TO (c) <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot herself on the forehead with a 22 gauge rifle.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>1.50</u> o. m. <u>8/20/57</u> 19 p. <u>3</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Odenton</u> <u>A.A.</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 24, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		23d. REC'D BY REGISTRAR <u>Aug 23 1957</u>	
ADDRESS <u>Glen Burnie</u>		23b. REGISTRAR'S SIGNATURE <u>Clara Schupp</u>	

BUREAU V. S.

AUG 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08146

CERTIFICATE OF DEATH

Reg. Dist. No.

081721

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Jones Station</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Jennings</u> Last <u>Tennings</u>		4. DATE OF DEATH Month <u>8</u> Day <u>9</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cal.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-57</u>
9. AGE (In years last birthday) yrs. <u>0</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shulton Jennings</u>		14. MOTHER'S MAIDEN NAME <u>Coke Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>776X</u>	
17. INFORMANT <u>Shulton Jennings - Jones Md.</u>		Address <u>612 Cathedral St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurely</u> DUE TO <u>776X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-9-57</u> , 19 <u>57</u> , to <u>8-9-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-9-57</u> , 19 <u>57</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>612 Cathedral St Annapolis Md.</u> DATE SIGNED <u>8-10-57</u>			
ACTUAL SIGNATURE <u>A.T. Allen</u>		M.D. <u>C. L. Cathedral St</u>	
PHYSICIAN'S NAME (Type) <u>A.T. ALLEN</u>		<u>Annapolis Md.</u>	
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-11-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carpenters Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Sound Bay, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Anna Md.</u>		ADDRESS <u>2063332 XVO</u>	
24a. REC'D BY REGISTRAR <u>AUG 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>M. J. Church</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		EDUCATION		OCCUPATION		MARRIAGE		RELIGION	
JAMES H. HARRIS		JAN 15 1895		M		W		H		H		M		M	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE, MD		AUG 22 1957		10:30 PM		HEART DISEASE		NATURAL		HOME		AUG 24 1957		CATHOLIC CHURCH	
PREVIOUS ILLNESS		DATE OF LAST ILLNESS		DATE OF LAST PHYSICIAN VISIT		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF NURSE		NAME OF BURIAL HOME		NAME OF MINISTER	
NONE		AUG 15 1957		AUG 15 1957		DR. J. H. HARRIS		BALTIMORE HOSPITAL		J. H. HARRIS		BALTIMORE BURIAL HOME		FR. J. H. HARRIS	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF BURIAL HOME		SIGNATURE OF NURSE		SIGNATURE OF HOSPITAL		SIGNATURE OF DEPARTMENT	
		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 8

AUG 22 1957

RECEIVED

TO FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08200

CERTIFICATE OF DEATH

08180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>1 yr, 2 mos, 26 ds</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>2124-2</u> ✓
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		d. STREET ADDRESS <u>157 N. Jonathan Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Crawley</u> Middle _____ Last <u>Jones</u>		4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1882 ?</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Hospital Records</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>May 11,</u> 19 <u>56</u> , to <u>August 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 6</u> , 19 <u>57</u> , and that death occurred at <u>4:05 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Conwell Newton</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M. D.</u>		DATE SIGNED _____	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Anatomy Bldg. of Md.</u>	22d. LOCATION (City, town, or county) _____ (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____		24a. REC'D BY REGISTRAR DATE _____	24b. REGISTRAR'S SIGNATURE <u>Wm. R. Reese Jr.</u>

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

See 504.50

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. RACE [REDACTED]</p>	
<p>5. DATE OF BIRTH [REDACTED]</p>		<p>6. PLACE OF BIRTH [REDACTED]</p>	
<p>7. DATE OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS [REDACTED]</p>	

BUREAU V. 2

JUN 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08181

08147

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>185 Prince George St.</u>				d. STREET ADDRESS <u>88 East St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>GEORGE PETER GEORGE KARANGELN</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/26/1876</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurment</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Karangelen</u>		Address <u>Summer Rd. Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis-Heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>8-13, 1957</u> , that I last saw the deceased alive on <u>8-12, 1957</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD</u> DATE SIGNED <u>8-15-57</u>							
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.							
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/16/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>V. Ormick</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 19 1957

RECEIVED

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		RACE [Faint text, possibly "White"]	
DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]		PLACE OF BIRTH [Faint text, possibly "New York, N.Y."]		US BIRTH REGISTRATION NO. [Faint text, possibly "123456789"]	
DATE OF DEATH [Faint text, possibly "Aug 18, 1957"]		PLACE OF DEATH [Faint text, possibly "New York, N.Y."]		US DEATH REGISTRATION NO. [Faint text, possibly "987654321"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		MEDICAL EXAMINER'S SIGNATURE [Faint signature]	
SIGNATURE OF DECEASED [Faint signature]		SIGNATURE OF NEXT OF KIN [Faint signature]		SIGNATURE OF MEDICAL EXAMINER [Faint signature]	
SIGNATURE OF CLERK [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF JUDGE [Faint signature]	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08182

08148

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON 47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. Hospital</u>				d. STREET ADDRESS <u>3811 S. DAKOTA-</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>H.</u> Last <u>KELLER</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-75</u>	9. AGE (In years birth day) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID KELLER</u>				14. MOTHER'S MAIDEN NAME <u>Marie Bracken - MAREBARET</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Bertha T. McCloskey - 3811 S. Dakota Ave NW Wash DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Bronchopneumonia.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Aug 3</u> , 19 <u>57</u> , to <u>Aug 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 6</u> , 19 <u>57</u> , and that death occurred at <u>1:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Richard N. Peelen</u> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8-9-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Proper Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JW Lee Sen. Wash. D.C.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>Aug 8 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08183

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>2 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>home of relative</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u> d. STREET ADDRESS <u>none</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ida</u> <u>Estelle</u> <u>King</u> Last 4. DATE OF DEATH Month <u>8</u> Day <u>28</u> Year <u>19 57</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>11.26.1889</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Prime Point Md.</u> 11. BIRTHPLACE (State or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>YES</u>	
13. FATHER'S NAME <u>James Stallings</u>		14. MOTHER'S MAIDEN NAME <u>Maly Crosby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>John W. King</u> 17. INFORMANT <u>Upper Marboro, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>151X</u> DUE TO <u>cancer of the stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8.28</u> , 19 <u>57</u> , to <u>8.28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8.28. 9 P.M.</u> , 19 <u>57</u> , and that death occurred at <u>10.20 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew D. Szabo</u>		ADDRESS (Street, city or town, state) <u>701 Westway, Glen Burnie, Md.</u> DATE SIGNED <u>8-29-57</u>	
PHYSICIAN'S NAME (Type) <u>Andrew D. Szabo, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 31, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Md. Queens</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hutchins</u> ADDRESS <u>Queens, Md.</u>		24a. REC'D BY REGISTRAR <u>8/30/57</u> 24b. REGISTRAR'S SIGNATURE <u>James F. Hutchins</u>	

BUREAU V. S.

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08184

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gibson Island		c. LENGTH OF STAY IN 1b 12 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 P.O. Pasadena			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In the Bath House				d. STREET ADDRESS Boulevard Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Phillip First W. Kurth Middle W. Last Kurth				4. DATE OF DEATH 8/13/57 Month 8 Day 13 Year 1957			
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/5/84	
9. AGE (In years) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Pvt Club		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Casper Kurth				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-9186		17. INFORMANT Mrs. P.W. Kurth (wife) Address same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 16, 57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING AND KIRKLEY				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR 8/15/57	
				24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - DIVISION 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU X. B.

JUG 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08203

CERTIFICATE OF DEATH

Reg. Dist. No. 08185-24

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie x 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #2 Oak Lane, S.W.				d. STREET ADDRESS #2 Oak Lane S.W.			
3. NAME OF DECEASED (Type or print) CHARLES MARSHAL LAKE				4. DATE OF DEATH Month August Day 1 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1884		9. AGE (In years lost birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Realtor (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles R. Lake				14. MOTHER'S MAIDEN NAME Florence V. Rixey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-07-4104		17. INFORMANT Mrs. Pauline S. Lake		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-Vascular Disease DUE TO (c) 10 yrs.						INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 47 , to Aug. 1 , 19 57 , that I last saw the deceased alive on July 31 , 19 57 , and that death occurred at 1:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 108 Central Ave., Glen Burnie, Md. DATE SIGNED 8/2/57							
ACTUAL SIGNATURE James S. Billingslea		M.D. James S. Billingslea					
PHYSICIAN'S NAME (Type) James S. Billingslea		ADDRESS 108 Central Ave., Glen Burnie, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery, Brooklyn, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. Billingslea				ADDRESS Glen Burnie, Md.		24. REGISTRAR'S SIGNATURE R. J. Billingslea	

CERTIFICATE OF DEATH

<p>NAME OF DECEASED [Faint text]</p>		<p>AGE [Faint text]</p>	
<p>SEX [Faint text]</p>		<p>RACE [Faint text]</p>	
<p>DATE OF BIRTH [Faint text]</p>		<p>DATE OF DEATH [Faint text]</p>	
<p>PLACE OF BIRTH [Faint text]</p>		<p>PLACE OF DEATH [Faint text]</p>	
<p>CAUSE OF DEATH [Faint text]</p>		<p>MANNER OF DEATH [Faint text]</p>	
<p>DIAGNOSIS [Faint text]</p>		<p>POST-MORTEM [Faint text]</p>	
<p>DATE OF EXAMINATION [Faint text]</p>		<p>TIME OF EXAMINATION [Faint text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>SIGNATURE OF CORONER [Faint text]</p>	
<p>DATE OF SIGNATURE [Faint text]</p>		<p>TIME OF SIGNATURE [Faint text]</p>	

BUREAU V. 3

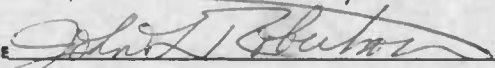
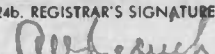
JUN 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

C8204

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL, MD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G MEADE				c. LENGTH OF STAY IN lb 29 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22 0353.2 ✓				d. STREET ADDRESS 7403 DUNMAN WAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US ARMY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDNA Middle M Last MARTIN				4. DATE OF DEATH Month AUG Day 17 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 JUL 1898	9. AGE (In years lost birthday) yrs. 59	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME FLETCHER J SHECKELS				14. MOTHER'S MAIDEN NAME MARY F WATERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT FRANK C MARTIN 7403 DUNMAN WAY BALTO, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD WITH CONGESTED FAILURE AND ASCITIS DUE TO (c) DIABETES MELLITUS WITH NEPHROSIS AND EARLY UREMIA							INTERVAL BETWEEN ONSET AND DEATH 12 HRS. 2 MONS 17 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 20 JULY 1957 , to 17 AUG 1957 , that I last saw the deceased alive on 17 AUG 1957 , and that death occurred at 1200 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) USA HOSPITAL FT. GEORGE G MEADE DATE SIGNED 17 AUG 57							
ACTUAL SIGNATURE 		M.D. USA HOSPITAL FT. GEORGE G MEADE 17 AUG 57					
PHYSICIAN'S NAME (Type) JOHN G. ROBERTSON CAPT. MD.		USA HOSPITAL FORT GEORGE G MEADE 17 AUG 57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 20, 1957	22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) Balto		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Evans - 5a. Charles St				ADDRESS 1400 -		24a. REC'D BY REGISTRAR AUG 20 57	24b. REGISTRAR'S SIGNATURE 

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

JUN 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08187

Reg. Dist. No. **27**

08205

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton			c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same <i>x2</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 Monterey Avenue				d. STREET ADDRESS Same		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle M. Last MCNAMARA				4. DATE OF DEATH Month August Day 6 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1905	
9. AGE (In years last birthday) 52 yrs.		10. FUNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) York, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professional Dancer				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) York, Pennsylvania	
13. FATHER'S NAME Thomas McNamara				14. MOTHER'S MAIDEN NAME Helen O'Brien			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 2		17. INFORMANT Address Mrs. Dennis Dell (Sister) Odenton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 hours
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED August 6, 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/9/57		Mt. Olivet		Hammer Pa York Co	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Frederick Buckner Hammer Co</i>				24a. REC'D BY REGISTRAR DATE 6 Aug 57		24b. REGISTRAR'S SIGNATURE <i>Wilbur H. Downs, Jr. Capt. MSC</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file prior to burial, cremation, or removal.

AUG 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08188

08149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>		d. STREET ADDRESS <u>Apt. 1102 Dream's Landing</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joan</u> Middle <u>Ann</u> Last <u>MODE</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 August 1957</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul Joseph MODE</u>		14. MOTHER'S MAIDEN NAME <u>Clair A. BROWSKE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Immaturity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>40 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>21 August</u> , 19 <u>57</u> , to <u>21 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>21 August</u> , 19 <u>57</u> , and that death occurred at <u>7:35A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard D. Sheehan</u> M.D.		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Richard D. SHEEHAN</u>		DATE SIGNED <u>8-21-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sns</u>		24a. REC'D BY REGISTRAR <u>8/22/57</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>O. Ormick</u>	

2051244XVO

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. RACE [Faint text]	
5. DATE OF DEATH [Faint text]		6. TIME OF DEATH [Faint text]		7. PLACE OF DEATH [Faint text]		8. CITY [Faint text]	
9. COUNTY [Faint text]		10. STATE [Faint text]		11. ZIP CODE [Faint text]		12. MARRIAGE [Faint text]	
13. OCCUPATION [Faint text]		14. CAUSE OF DEATH [Faint text]		15. MANNER OF DEATH [Faint text]		16. SIGNATURE OF PHYSICIAN [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF WITNESS [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]		23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF WITNESS [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF WITNESS [Faint text]		27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF WITNESS [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF WITNESS [Faint text]		31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF WITNESS [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF WITNESS [Faint text]		35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF WITNESS [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF WITNESS [Faint text]		39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF WITNESS [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF WITNESS [Faint text]		43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF WITNESS [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF WITNESS [Faint text]		47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF WITNESS [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF WITNESS [Faint text]		51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF WITNESS [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF WITNESS [Faint text]		55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF WITNESS [Faint text]	
57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF WITNESS [Faint text]		59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF WITNESS [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]		63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF WITNESS [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF WITNESS [Faint text]		67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF WITNESS [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF WITNESS [Faint text]		71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF WITNESS [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF WITNESS [Faint text]		75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF WITNESS [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF WITNESS [Faint text]		79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF WITNESS [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]		83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF WITNESS [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF WITNESS [Faint text]		87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF WITNESS [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF WITNESS [Faint text]		91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF WITNESS [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF WITNESS [Faint text]		95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF WITNESS [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF WITNESS [Faint text]		99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF WITNESS [Faint text]	

BUREAU V. S.

AUG 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08206

CERTIFICATE OF DEATH

08189

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3001-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		d. STREET ADDRESS <u>Unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Moreland</u>		4. DATE OF DEATH Month <u>8</u> Day <u>27</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-13-1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Moreland</u>		14. MOTHER'S MAIDEN NAME <u>Jane Moreland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>- - - - -</u>		16. SOCIAL SECURITY NO. <u>- - - - -</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>- - - - -</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Brain Syndrome - Bilateral Inguinal Hernia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-13-57</u> , 19 <u>57</u> , to <u>8-27-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-27-</u> , 19 <u>57</u> , and that death occurred at <u>9:10 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u> DATE SIGNED <u>8-27-57</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. <u>Crownsville, Maryland</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>8-29-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>University of Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Rose</u>		24a. REC'D BY REGISTRAR <u>8/30/57</u>	
ADDRESS <u>108 Washington</u>		24b. REGISTRAR'S SIGNATURE <u>X. M. Jones</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU

SEP - 3 - 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon poppers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08150

CERTIFICATE OF DEATH

08190

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Fishing Creek Farm R 7 D. R</u>	
d. NAME OF HOSPITAL (If non-institution, give street address) <u>U. S. General</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MURCHAKE</u> Last <u>MURCHAKE</u>		4. DATE OF DEATH Month <u>8</u> Day <u>29</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27th 1898</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Bridgeport Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael Murchake</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>()</u>	
17. INFORMANT <u>Mary Ann Murchake</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u> (b) <u>ARTERIOSCLEROTIC CORONARY ARTERY DIS.</u> DUE TO <u>ARTERIOSCLEROTIC CARDIO-VASC. DIS</u> (c) <u>ARTERIOSCLEROTIC CARDIO-VASC. DIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 HRS</u> <u>16 YRS.</u> <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY, 1955</u> , to <u>29 AUG, 1957</u> , that I last saw the deceased alive on <u>29 AUG, 1957</u> , and that death occurred at <u>7:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward S. Beck</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8/30/57</u>	
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-6-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Fay</u>		24a. RECEIVED BY REGISTRAR <u>9/3/57</u> 24b. REGISTRAR'S SIGNATURE <u>V. D. Smith</u>	

UREAU V. 3

SEP 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 8 Film 220 8-16-57 et
08207 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 7 Film 220 9-11-57 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. No.

0819124

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bellehaven Beach		d. STREET ADDRESS 3845 Quarry Avenue	
3. NAME OF DECEASED (Type or print) First CHARLES Middle FRANCIS Last MURK		4. DATE OF DEATH Month August Day 28 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 8, 1915
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Consolidated Del.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence P. Murk		14. MOTHER'S MAIDEN NAME ? MELVIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-05-1164	
17. INFORMANT Mrs. Nellie M. Murk 3845 Quarry Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9298 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned	
20c. TIME OF INJURY Month, Day, Year 8:17 p.m. Aug. 28 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Water		20f. (City or town) Anne Arundel (County) (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 31/57	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) Woodlawn Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Norman - 3818 Pocomoke		24a. REC'D BY REGISTRAR	
		24b. REGISTRAR'S SIGNATURE L. J. Adkins	

SEP 3 1957

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 5

SEP 3 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08208

1. PLACE OF DEATH o. COUNTY Anne Arundal MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Balto City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto City, Md.			
c. LENGTH OF STAY IN 1b 5y, 4m, 11d				d. STREET ADDRESS 118 N Mount St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Roland Middle Harry Last Nash				4. DATE OF DEATH Month 8 Day 30 Year 1957			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30 ?? 1898 ?	
9. AGE (In years last birthday) yrs. 59 ?		IF UNDER 1 YEAR Months 8 Days 30		IF UNDER 24 HRS. Hours 19 Min. 57			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobber				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Nash				14. MOTHER'S MAIDEN NAME Rosetta Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records of Crownsville State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heartfailure 023x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syphilitic and arteriosclerotic cardiovascular disease DUE TO (c) unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May, 20 , 1952, to August, 30 , 1957, that I last saw the deceased alive on 8/30/57 , and that death occurred at 9.25pM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ludwig Benedict				ADDRESS (Street, city or town, state) Crownsville State Hospital			
PHYSICIAN'S NAME (Type) Ludwig Benedict, M.D.				DATE SIGNED 8/31/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Kate R. Williams				ADDRESS 322 N. Schmale		24a. REC'D BY REGISTRAR SEP 4 1957	
				24b. REGISTRAR'S SIGNATURE K. M. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08193 21

08151

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Shadyside</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Franklin & Cathedral Sts.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>NOT NAMED</u> <u>Nick</u>		4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>19 57</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/57</u>
9. AGE (In years last birthday) <u>14 yrs</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>???</u>		14. MOTHER'S MAIDEN NAME <u>Velma C. NICK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Shadyside Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776 X</u> DUE TO (c) <u>776 X</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7/31</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31</u> 19 <u>57</u> , to <u>8/1</u> 19 <u>57</u> , that I last saw the deceased alive on <u>8/1</u> 19 <u>57</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>69 Franklin St Annapolis, Md</u>	
ACTUAL SIGNATURE <u>Robert A. Riley Jr.</u> M.D.		DATE SIGNED <u>8/7/57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. RILEY, Jr</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 8/1957</u>	22b. DATE THEREOF <u>Aug 8/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Matthews</u>	22d. LOCATION (City, town, or county) (State) <u>Shadyside Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. French</u>		ADDRESS <u>Annapolis</u>	
24a. REC'D BY REGISTRAR <u>Aug 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Thos. J. French</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. MARITAL STATUS	
7. PLACE OF BIRTH		8. DATE OF BIRTH		9. DATE OF DEATH	
10. PLACE OF DEATH		11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGY	
19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF HEALTH DEPARTMENT		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF JUDGE	
25. SIGNATURE OF DISTRICT ATTORNEY		26. SIGNATURE OF SHERIFF		27. SIGNATURE OF TOWNSHIP CLERK	
28. SIGNATURE OF VOTING CLERK		29. SIGNATURE OF SCHOOL CLERK		30. SIGNATURE OF CHURCH CLERK	
31. SIGNATURE OF POST OFFICE CLERK		32. SIGNATURE OF RAILROAD CLERK		33. SIGNATURE OF AIRPORT CLERK	
34. SIGNATURE OF MARINE CLERK		35. SIGNATURE OF NAVY CLERK		36. SIGNATURE OF ARMY CLERK	
37. SIGNATURE OF AIR FORCE CLERK		38. SIGNATURE OF SPACE CLERK		39. SIGNATURE OF NUCLEAR CLERK	
40. SIGNATURE OF OTHER CLERK		41. SIGNATURE OF OTHER CLERK		42. SIGNATURE OF OTHER CLERK	

BUREAU V. S.

AUG 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08152 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08194

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>5361-CHILLUM. N.E. Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>C.</u> Last <u>OVERST</u>				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/7/1941</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>Robert P. Oberst</u>				14. MOTHER'S MAIDEN NAME <u>Louise Price</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs. Louise Kruse - 5361 Chillum Place</u> Address <u>N.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull - multiple lacerations</u> 825X DUE TO (b) <u>Free</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident R#2</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>5-17</u> a. m. <u>PM</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>A.A. Co</u> (County) <u>MD</u> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. - Arlington, Virginia</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St. N.W.</u>				ADDRESS <u>Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>AUG 19 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Finch</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 2

AUG 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups		c. LENGTH OF STAY IN 1b Over 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 175				d. STREET ADDRESS Route 175		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS RICHARD O'NEILL				4. DATE OF DEATH Month Day Year August 18 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/01	
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired guard of Md. House Correction.		11. BIRTHPLACE (State or foreign country) Guilford, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael O'Neill				14. MOTHER'S MAIDEN NAME Unknown Mary Welsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-36-8730		17. INFORMANT Address Mrs. Margaret J. Athey (daughter)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Liver with Ulcerative Esophagitis and Gastro-Intestinal Hemorrhage. 581.0 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/19/57	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/57.		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Laurel, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Sand, Catonsville, 28, Md				24a. REC'D BY REGISTRAR AUG 21 1957		24b. REGISTRAR'S SIGNATURE Cara Schupp	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John J. Smith		45		Male		White		1957		Boston, Mass.	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Social Status	
Heart Disease		Natural		Teacher		High School		Married		Middle Class	
Date of Birth		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Disposition	
1912		1957		1957		1957		1957		1957	
Place of Birth		Place of Death		Place of Burial		Place of Interment		Place of Cremation		Place of Disposition	
New York		Boston		Boston		Boston		Boston		Boston	
Date of Death		Date of Death		Date of Death		Date of Death		Date of Death		Date of Death	
1957		1957		1957		1957		1957		1957	
Place of Death		Place of Death		Place of Death		Place of Death		Place of Death		Place of Death	
Boston		Boston		Boston		Boston		Boston		Boston	

BUREAU V. 3

AUG 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08153

CERTIFICATE OF DEATH

08196

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				d. STREET ADDRESS 80 West Washington Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Baby boy Middle Parker Last Parker				4. DATE OF DEATH Month August Day 7 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1957	9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	IF UNDER 24 HRS. Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Louis Landale Smith				14. MOTHER'S MAIDEN NAME Myrtle Effie Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address 80 W. Washington Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7620 Atelectasis of both lungs DUE TO Cause unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cause unknown DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Maturity Syndrome							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6, 1957 , to August 7, 1957 , that I last saw the deceased alive on August 7, 1957 , and that death occurred at 2:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE R. L. Richardson				ADDRESS (Street, city or town, state) 110-CLAY ST ANNAPOLIS MD			
DATE SIGNED 8/7/57							
PHYSICIAN'S NAME (Type) Dr. R. L. Richardson				Clay St., Annapolis, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-13-57		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William E. Ewing, Jr.				ADDRESS 110-CLAY ST ANNAPOLIS MD		24a. REC'D BY REGISTRAR AUG 22 1957	
				24b. REGISTRAR'S SIGNATURE Wm. J. Hanks			

2063248XV5

AUG 22 1957

BUREAU V. S.

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08197

08210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>A. A. Co.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>DEALE</u> TOWN <u>DEALE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>AA Co</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Deale, Md.</u> TOWN <u>Deale, Md.</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>BERNARD</u> <u>LUCIUS</u> <u>PHIPPS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug 26</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov. 8, 1890</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>66</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
11. BIRTHPLACE (State or foreign country) <u>Churchton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Phipps</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Christine Atwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-36-8893</u>	
17. INFORMANT & ADDRESS <u>LENA Phipps Deale, Md</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>442X IMMEDIATE CAUSE (A) Complete Heart Block</u> ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic C.V.R. Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>10 yrs</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19 54</u> , to <u>26 Aug 57</u> , that I last saw the deceased alive on <u>25 Aug 57</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Deale, Md</u>	
DATE SIGNED <u>30 Aug 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Aug 29 1957</u>	
NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>		LOCATION (City, town, or county) (State) <u>Tracy's Landing, Md</u>	
24. REGD BY REGISTRAR <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Galesville Md</u>	
DATE <u>9/6/57</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08198

08211

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Mexico</u> b. COUNTY <u>Bernalillo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Albuquerque</u> <u>68X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>824 Adams Street, N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>LAWRENCE</u> Last <u>PIRKLE</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>21/August/57</u>	
9. AGE (In years last birthday) yrs. <u>25</u>		IF UNDER 1 YEAR Months <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Lowell Zinn Pirkle</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Lou Kitch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Father, 609 Fairlawn Avenue, Apt 5, Laurel, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neoplasm in retroperitoneal space</u> DUE TO <u>Incomplete expansion of both lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>0300 21 Aug 1957</u> to <u>22 Aug 1957</u> , that I last saw the deceased alive on <u>22 Aug 1957</u> , and that death occurred at <u>0403 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>John P. Bergstrom</u> M.D. <u>USAH, Fort G. G. Meade, Md.</u> <u>22 Aug 57</u>							
PHYSICIAN'S NAME (Type) <u>BERGSTROM JOHN P. CAPT. M.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>Aug. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>	
22d. LOCATION (City, town, or county) _____ (State) _____							
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u> <u>1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>22 Aug 57</u>		24b. REGISTRAR'S SIGNATURE <u>Wilbur H. Downs, Jr. Capt. MSC</u>	

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RECEIVED

AUG 23 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08212

CERTIFICATE OF DEATH

08199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNEAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>		d. STREET ADDRESS <u>1 RFD #2, Box 592</u>	
3. NAME OF DECEASED (Type or print) First <u>Vesta</u> Middle <u>Porter</u> Last <u>Porter</u>		4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Porter</u>		14. MOTHER'S MAIDEN NAME <u>Frances Porter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition and Dehydration</u> <u>355X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Old Post Traumatic Cerebral Atrophy</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) <u>Microcephaly</u> 2) <u>Anemia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. g. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-20-</u> , 19 <u>57</u> , to <u>8-23-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-23</u> , 19 <u>57</u> , and that death occurred at <u>9:30a</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>		ADDRESS (Street, city or town, state) <u>Crownsville, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M.D.</u>		DATE SIGNED <u>8-23-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arnold, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Anna, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/57</u>	
24b. REGISTRAR'S SIGNATURE <u>R. M. Jones</u>			

AUG 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08154

CERTIFICATE OF DEATH

08200 21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1029 Smithville St.</u>		d. STREET ADDRESS <u>1029 Smithville St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Gladys</u> Middle <u>M</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>8</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1919</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Makell</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Biss</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Agnes Makell - Annapolis, Md.</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 1, 1955</u> , to <u>8/25/57</u> , that I last saw the deceased alive on <u>8/25/57</u> , 19 <u> </u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. F. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, MD.</u>	
DATE SIGNED <u>8/25/57</u>		DATE SIGNED <u>8/25/57</u>	
PHYSICIAN'S NAME (Type) <u>William Reese, Jr. - Annapolis, Md.</u>		22a. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	
22b. DATE THEREOF <u>8-29-57</u>		22c. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>AUG 28 1957</u>		DATE <u> </u>	

BUREAU V. S.

AUG 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08213

CERTIFICATE OF DEATH

08201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103 - 1st Ave. South</u>		d. STREET ADDRESS <u>103 - 1st Ave. South</u>	
3. NAME OF DECEASED (Type or print) <u>Effie Elizabeth Pumphrey</u>		4. DATE OF DEATH <u>Aug 23</u> Day Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1918</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ferndale, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm H. Downs</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Luther Pumphrey</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> <u>422.1</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 am - 10 pm</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1945</u> to <u>Aug 23 1957</u> , that I last saw the deceased alive on <u>Aug 5 1957</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas L. Ball Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Linthicum, Md.</u> DATE SIGNED <u>8/23/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Vickers & Sons</u>		24. REG'D BY REGISTRAR <u>Aug 27 1957</u> 24b. REGISTRAR'S SIGNATURE <u>L. J. Sealby</u>	

CERTIFICATE OF DEATH

Form 100-100

1. Name of deceased (Print or write full name as on birth record)

2. Date of death

3. Sex

4. Race

5. Place of birth (State, county, city or town)

6. Usual residence at time of death

7. Cause of death (Specify if known)

8. Manner of death

9. Occupation

10. Marital status

11. Education

12. Religion

13. Date of birth

14. Date of death

15. Date of burial

16. Date of cremation

17. Date of interment

18. Date of exhumation

19. Date of autopsy

20. Date of necropsy

21. Date of examination

22. Date of certification

23. Date of registration

24. Date of filing

25. Date of completion

26. Date of return

27. Date of receipt

28. Date of acknowledgment

29. Date of acceptance

30. Date of delivery

31. Date of presentation

32. Date of distribution

33. Date of publication

34. Date of circulation

35. Date of exposure

36. Date of development

37. Date of printing

38. Date of binding

39. Date of mailing

40. Date of delivery

41. Date of receipt

42. Date of acknowledgment

43. Date of acceptance

44. Date of delivery

45. Date of presentation

46. Date of distribution

47. Date of publication

48. Date of circulation

49. Date of exposure

50. Date of development

51. Date of printing

52. Date of binding

53. Date of mailing

54. Date of delivery

55. Date of receipt

56. Date of acknowledgment

57. Date of acceptance

58. Date of delivery

59. Date of presentation

60. Date of distribution

61. Date of publication

62. Date of circulation

63. Date of exposure

64. Date of development

65. Date of printing

66. Date of binding

67. Date of mailing

68. Date of delivery

69. Date of receipt

70. Date of acknowledgment

71. Date of acceptance

72. Date of delivery

73. Date of presentation

74. Date of distribution

75. Date of publication

76. Date of circulation

77. Date of exposure

78. Date of development

79. Date of printing

80. Date of binding

BUREAU V. S.

AUG 28 1957

RECEIVED

08155

CERTIFICATE OF DEATH

08202

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Bay Ridge) Annapolis X 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 34 River Rd.			
3. NAME OF DECEASED (Type or print) ALBERT A RILEY				4. DATE OF DEATH August 20 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1900	
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Specialist		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Riley				14. MOTHER'S MAIDEN NAME May Cash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Kathleen V. Riley- Wife- Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X DUE TO mythical Stenosis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rheumatic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old multiple kidney infarction							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Feb 7 , 19 57 to 8-20 , 19 57 , that I last saw the deceased alive on 8-20-57 , 19 57 , and that death occurred at 6-7 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank M Shipley M.D.				ADDRESS (Street, city or town, state) 63 College Ave. Annapolis, Maryland			
DATE SIGNED 8.22.57							
PHYSICIAN'S NAME (Type) Frank Shipley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 24, 57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR 8/27/57	
				24b. REGISTRAR'S SIGNATURE Mr. J. French			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mostly illegible due to blurring and bleed-through.

BUREAU V. 1

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08214

CERTIFICATE OF DEATH

08203

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 1mo. 1wk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State		d. STREET ADDRESS 1108 Greenmont Avenue	
3. NAME OF DECEASED (Type or print) First Doretta Middle Ross Last Ross		4. DATE OF DEATH Month 8 Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 28, 1920
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 3 Days 25 Hours 19 Min. 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Calvin Ross		14. MOTHER'S MAIDEN NAME Mary Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hospital Records		Address Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration and Hyperglycemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 7, 19 57 , to August 25, 19 57 , that I last saw the deceased alive on 8-25-57 , and that death occurred at 5:10 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-26-57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-30-57	
22c. NAME OF CEMETERY OR CREMATORY University of Md		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Keese #1687 Wash St Annapo		ADDRESS ---	
24a. REC'D BY REGISTRAR 9/3/57		24b. REGISTRAR'S SIGNATURE K. M. Joyce	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08215

CERTIFICATE OF DEATH

08204

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 412 - Lake Shore</u>				d. STREET ADDRESS <u>Box 412 - Lake Shore</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Rothamel</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-21, 1864</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Ba Har Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>George Rothamel</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Zimmerman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mrs. Mary Rothamel Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular disease</u> DUE TO (c) <u>several months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 20</u> , 19 <u>55</u> , to <u>Aug 6</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 5</u> , 19 <u>57</u> , and that death occurred at <u>2:07 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin, M.D.</u>				DATE SIGNED <u>August 6, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Smith</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>L. J. Adkins</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>AUG 12 1957</u>			

BUREAU V. S.

AUG 12 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08216

CERTIFICATE OF DEATH

08205

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 16 4 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3801-4		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1127 Pennsylvania Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lester Saunders		4. DATE OF DEATH Month Day Year 8 17 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 56? yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident (cerebral hemorrhage) 026x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CNS Lues DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH 10 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. ----- 79 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 17, 19 57, to August 17, 19 57, that I last saw the deceased alive on August 17, 19 57, and that death occurred at 12:08 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE Conwell Newton, M.D.		ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.	
DATE SIGNED 8/20/57			
PHYSICIAN'S NAME (Type) Conwell Newton, M. D.		Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 21	
22c. NAME OF CEMETERY OR CREMATORY Mt Carmel		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE G. H. Hulse		ADDRESS P. O. Box 1111	
24a. REC'D BY REGISTRAR DATE 8/23/57		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

BUREAU V. S.

JUG 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08156

CERTIFICATE OF DEATH

0820621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Millersville Rural				d. STREET ADDRESS Crownsville Post Office			
3. NAME OF DECEASED (Type or print) First Charles Middle B Last Smith				4. DATE OF DEATH Month August Day 14 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 6, 1883 1957	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.		IF UNDER 24 HRS. Months 73 Days 73 Hours 73 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storkeeper				10b. KIND OF BUSINESS OR INDUSTRY State Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles B. Smith				14. MOTHER'S MAIDEN NAME Annie Insley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Charles O. Smith; Son; Gambrills, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 Hour 5 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct , 19 56 , to Aug 14 , 19 57 , that I last saw the deceased alive on Aug 10 , 19 57 , and that death occurred at 8:25AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward G. Skerritt				ADDRESS (Street, city or town, state) Gambrills		DATE SIGNED 8-14-57	
PHYSICIAN'S NAME (Type) Edward Skerritt							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-17-57		22c. NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cem.		22d. LOCATION (City, town, or county) (State) Millersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR AUG 19 1957	
				24b. REGISTRAR'S SIGNATURE Mr. J. Church			

CERTIFICATE OF DEATH

1957

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1892		NEW YORK	
CITY OF RESIDENCE		STREET ADDRESS		CITY		STATE		ZIP CODE		COUNTRY	
BOSTON		123 MAIN ST		BOSTON		MA		02108		USA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
AUG 15 1957		10:30 AM		HOME		HEART DISEASE		NATURAL		12345	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF JUDGE	
TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS		TESTAMENTS	
I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.	
I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.		I, the undersigned, being a duly qualified and sworn physician, do hereby certify that the above named deceased person died on the day and at the place and from the cause and in the manner stated above.	

BUREAU V. 3

AUG 19 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08157 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08207

21

1. PLACE OF DEATH a. COUNTY <i>A.A.CO</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince George's</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville 1615.2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Emergency Hospital (A.A.CO)</i>			d. STREET ADDRESS <i>3200 Kimberley Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>CHARLOTTE ANN Smith</i>			4. DATE OF DEATH Month <i>8</i> Day <i>17</i> Year <i>1957</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 15, 1943</i>		9. AGE (In years last birthday) <i>14</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>School</i>		11. BIRTHPLACE (State or foreign country) <i>Washington D. C.</i>	
13. FATHER'S NAME <i>Melvin E. Smith</i>			14. MOTHER'S MAIDEN NAME <i>Cleo G. Fisher</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Melvin E. Smith W Hyattsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture - Skull - Multiple contusions</i> <i>825X</i> DUE TO <i>Lips, face, upper extremities</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>sudden</i> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident R#2</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>5-17 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>	
20f. (City or town) <i>A.A.CO.</i>		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>E. Linhardt</i>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <i>E. Linhardt</i>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/20/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>	
22d. LOCATION (City, town, or county) <i>Arlington Virginia</i>		22e. (State) <i>VA</i>		22f. REC'D BY REGISTRAR <i>Mr. Lenchy</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>			ADDRESS <i>Hyattsville, Md.</i>		

AUG 22 1957

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 22 1957

RECEIVED

CHARLOTTE ANN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08208

08158

1. PLACE OF DEATH a. COUNTY <i>A.A.CO.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Pro Seiger</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Hyattsville - 1615.2</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>ANNE ARUNDEL GENERAL.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CLEO G. Smith</i>		4. DATE OF DEATH Month <i>8</i> Day <i>17</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 23, 1922</i>
9. AGE (In years last birthday) <i>36</i> yrs.		IF UNDER 1 YEAR Months <i>36</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Texas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>John Fisher</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Melvin E. Smith</i>		Address <i>W Hyattsville, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture-Skull - Saw - Compd. Fracture</i> 816X DUE TO (b) <i>Lower-Extremities - Multiple - contusions</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <i>AND Lacerations.</i> Sudden.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto. accident - R 2</i>	
20c. TIME OF INJURY Month, Day, Year <i>5-17 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) <i>A.A.CO.</i> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 20, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington</i> (State) <i>Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Gasch's Sons</i>		ADDRESS <i>Hyattsville Md.</i>	
24a. REC'D BY REGISTRAR <i>Aug 22 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Th. J. Thendy</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper. Some legible fragments include:]

NAME OF DECEASED: *[illegible]*
 SEX: *[illegible]*
 AGE: *[illegible]*
 DATE OF DEATH: *[illegible]*
 PLACE OF DEATH: *[illegible]*
 CAUSE OF DEATH: *[illegible]*
 MANNER OF DEATH: *[illegible]*
 SIGNATURE OF EXAMINER: *[illegible]*
 OFFICE OF THE MEDICAL EXAMINER: *[illegible]*

CLEO

BUREAU V. 2

AUG 22 1957

RECEIVED

ORIGINAL FILED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08209

08159

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY in 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ce. General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM H. M. SMITH JR</u>		4. DATE OF DEATH Month Day Year <u>8 - 19 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-8-1936</u>
9. AGE (In years last birthday) <u>20</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. M. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Martha Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>W. H. M. Smith</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury to Pelvis</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Comp. fracture femur left</u> DUE TO (c) <u>suicide</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Cuts accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>12:05 8/19/57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Annapolis Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>F. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>F. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Annes</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>8/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>O. French</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		BIRTH		DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		CITY		STATE	

BUREAU V. S.

AUG 23 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. Co.			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 2 years			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Same			d. STREET ADDRESS Same			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																																																	
3. NAME OF DECEASED (Type or print) Marjorie A. Staubitz			First Middle Last			4. DATE OF DEATH August 23rd. 1957 19			Month Day Year			5. SEX F			6. COLOR OR RACE W			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 5/18/03			9. AGE (In years last birthday) 54 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.			11. IF UNDER 24 HRS.																																																					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Florence, Howard Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Louis Ridder			14. MOTHER'S MAIDEN NAME Ella Pickett			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None			17. INFORMANT Georges Staubitz (Husband) Same as # 2			Address																																																								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH Sudden			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)																																																								
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			ACTUAL SIGNATURE Gustave H. Faubert, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 8/24/57			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 27 Aug. 57			22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery			22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland																																																								
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]			ADDRESS Glen Burnie, Md.			24a. REC'D. BY REGISTRAR AUG 27 1957			24b. REGISTRAR'S SIGNATURE [Signature]			24c. REGISTRAR'S SIGNATURE [Signature]			24d. REGISTRAR'S SIGNATURE [Signature]			24e. REGISTRAR'S SIGNATURE [Signature]			24f. REGISTRAR'S SIGNATURE [Signature]			24g. REGISTRAR'S SIGNATURE [Signature]			24h. REGISTRAR'S SIGNATURE [Signature]			24i. REGISTRAR'S SIGNATURE [Signature]			24j. REGISTRAR'S SIGNATURE [Signature]			24k. REGISTRAR'S SIGNATURE [Signature]			24l. REGISTRAR'S SIGNATURE [Signature]			24m. REGISTRAR'S SIGNATURE [Signature]			24n. REGISTRAR'S SIGNATURE [Signature]			24o. REGISTRAR'S SIGNATURE [Signature]			24p. REGISTRAR'S SIGNATURE [Signature]			24q. REGISTRAR'S SIGNATURE [Signature]			24r. REGISTRAR'S SIGNATURE [Signature]			24s. REGISTRAR'S SIGNATURE [Signature]			24t. REGISTRAR'S SIGNATURE [Signature]			24u. REGISTRAR'S SIGNATURE [Signature]			24v. REGISTRAR'S SIGNATURE [Signature]			24w. REGISTRAR'S SIGNATURE [Signature]			24x. REGISTRAR'S SIGNATURE [Signature]			24y. REGISTRAR'S SIGNATURE [Signature]			24z. REGISTRAR'S SIGNATURE [Signature]		

MARYLAND STATE DEPARTMENT OF HEALTH
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. 3

AUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08160

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A A</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A.A. General</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
f. STREET ADDRESS <i>105 Monticello Ave</i>		g. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>SAMUEL</i> Middle <i>S</i> Last <i>STOKES</i>		4. DATE OF DEATH Month <i>8-</i> Day <i>9-</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-8-1885</i>
9. AGE (In years last birthday) <i>72</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner of Grocery Store (Grocery)</i>		12. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>John A. Stokes</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Zeigler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Samuel S. Stokes Jr.</i>		18. ADDRESS <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Cerebral Accident.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>Instant</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. L. L. L. L.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. L. L. L. L.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>8-9-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-12-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Skyles</i>		24a. REC'D BY REGISTRAR <i>9/10/57</i>	
ADDRESS <i>Annapolis</i>		24b. REGISTRAR'S SIGNATURE <i>H. L. L. L.</i>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

AUG 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 8 FilmG219 8-9-57 et
 08161
 CERTIFICATE OF DEATH

08212

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES MOORE STROMEYER				4. DATE OF DEATH Month Aug Day 3 Year 1957			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890 Nov. 11, 1889	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Moore				14. MOTHER'S MAIDEN NAME Minnie Grollman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT William F. Stromeier- Husband - same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Laemec's Certerosis, Hypertensive and Arteriosclerotic CV Disease						INTERVAL BETWEEN ONSET AND DEATH None	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 581.1		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from July 25, 1957 to Aug 3, 1957 , that I last saw the deceased alive on Aug 3, 1957 , and that death occurred at 120 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Maryland DATE SIGNED August 5, 1957							
ACTUAL SIGNATURE Richard H. Pooler M.D.				DATE SIGNED August 5, 1957			
PHYSICIAN'S NAME (Type) Richard Pooler				Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 6, 57		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR Aug 7 1957		24b. REGISTRAR'S SIGNATURE Wm. J. French	

CERTIFICATE OF DEATH

STATE OF MARYLAND

Form No. 10

10-10-10

1. NAME OF DECEASED JAMES ALFRED		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Salesman		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935	
9. PLACE OF DEATH Baltimore, Md.		10. CAUSE OF DEATH Heart Disease		11. DATE OF DEATH Aug 7, 1957		12. TIME OF DEATH 10:15 AM	
13. SIGNATURE OF DECEASED James Alfred		14. SIGNATURE OF WITNESS John Doe		15. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary Doe		16. SIGNATURE OF DECEASED'S PHYSICIAN Dr. John Smith	
17. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe		18. SIGNATURE OF DECEASED'S CHURCH St. John's Church		19. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe & Co.		20. SIGNATURE OF DECEASED'S BURIAL PLACE St. John's Cemetery	
21. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		22. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		23. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		24. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
25. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		26. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		27. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		28. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
29. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		30. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		31. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		32. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
33. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		34. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		35. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		36. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
37. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		38. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		39. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		40. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
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49. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		50. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		51. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		52. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
53. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		54. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		55. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		56. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
57. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		58. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		59. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		60. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
61. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		62. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		63. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		64. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
65. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		66. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		67. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		68. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
69. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		70. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		71. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		72. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
73. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		74. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		75. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		76. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
77. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		78. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		79. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		80. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
81. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		82. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		83. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		84. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
85. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		86. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		87. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		88. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
89. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		90. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		91. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		92. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
93. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		94. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		95. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		96. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	
97. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		98. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe		99. SIGNATURE OF DECEASED'S NEXT OF KIN Mary Doe		100. SIGNATURE OF DECEASED'S NEXT OF KIN John Doe	

BUREAU V. 1

AUG 7 1957

RECEIVED

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VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08218

08218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>20yrs. 4mo. 18da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle Last <u>Thomas</u>				4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1898?</u>	9. AGE (In years last birthday) <u>59?</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Hospital Records Crownsville, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Malnutrition</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1957</u> , to <u>August 20, 1957</u> , that I last saw the deceased alive on <u>August 20, 1957</u> , and that death occurred at <u>6:25 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Conwell Newton, M.D.</u>		M.D. <u>Crownsville, Maryland</u>		8-21-57			
PHYSICIAN'S NAME (Type) <u>Conwell Newton, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 8-27-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>University of Md.</u>		22d. LOCATION (City, town, or county) <u>Balto. Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Kessett</u>		ADDRESS <u>108 Wash. St.</u>		24a. REC'D BY REGISTRAR DATE <u>8/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>R. M. Jones</u>	

BUREAU V. 3

AUG 29 - 1957

RECEIVED
AUG 29

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08219

CERTIFICATE OF DEATH

08214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEEMS CREEK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEEMS CREEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEYETT ROAD</u>				d. STREET ADDRESS <u>MEYETT ROAD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH VIRGINIA TAYMAN THOMAS</u>				4. DATE OF DEATH Month Day Year <u>8 - 5 - 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7 - 28 - 1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PRI. GEO. Co. MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>JAMES TAYMAN</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Miss Ruth Thomas</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Artificial Hypertension</u> DUE TO (c) <u>Arterio Sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Analysis</u> <u>Analysis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>2 - 4</u> , 19 <u>57</u> , to <u>8 - 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 - 4</u> , 19 <u>57</u> , and that death occurred at <u>2:17</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. Oliver Purvis</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Annapolis Md 8/6/57</u>			
PHYSICIAN'S NAME (Type) <u>J. Oliver Purvis</u>				<u>Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST MARYS CEMT</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>8/7/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BUREAU V. S.

AUG 8 1957

RECEIVED

08162

CERTIFICATE OF DEATH

08215 21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Co.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. STREET ADDRESS <u>3531 Washington St.</u>		d. STREET ADDRESS <u>3531 Washington St.</u>	
3. NAME OF DECEASED (Type or print) <u>Patrice Thorne</u>		4. DATE OF DEATH <u>8/31/1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Young</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Nollway</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>Coira Knight</u>	
17. INFORMANT <u>Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion of Heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1951-1957</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/5</u> , 19 <u>51</u> , to <u>8/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/31</u> , 19 <u>57</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson</u> M.D.		ADDRESS (Street, city or town, state) <u>37 Robert Street Annapolis, Md.</u> DATE SIGNED <u>9/3/57</u>	
PHYSICIAN'S NAME (Type) <u>DR. THEODORE H. JOHNSON</u>		<u>MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest</u>	22d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 6 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Wm. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert Young
Male
Born 10-18-1890
Died 10-18-1957
Cause of Death: Coronary Thrombosis
Place of Death: Baltimore, Md.
Age: 67
Sex: Male
Race: White
Marital Status: Single
Occupation: Clerk
Signature: [illegible]
Date: 10-18-1957

BUREAU V. 5

SEP 6 1957

RECEIVED

Received 9-4-57
Baltimore, Md.

08163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>Cape Look Haven x0</u>			
3. NAME OF DECEASED (Type or print) First <u>FERN. D. KYLE</u> Middle <u>TOLSON</u> Last <u>TOLSON</u>				4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 21, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fort Wayne Indiana</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>William Kyle</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Frank F. Tolson</u> Address <u>Edgewater, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>416X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 Rheumatic heart disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>August 1</u> , 19 <u>57</u> , to <u>August 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>August 4, 9:30 AM</u> , 19 <u>57</u> , and that death occurred at <u>9:30 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.				ADDRESS (Street, city or town, state) <u>Franklin St. Annapolis, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard N. Peeler</u>				DATE SIGNED <u>Aug 7 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 7, 57</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Natl</u>	
22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u>				22e. (State) <u>Md.</u>		22f. (Country) <u>USA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				ADDRESS <u>Washington DC</u>		24a. REC'D BY REGISTRAR <u>Aug 7 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. J. Hensch</u>				24c. DATE		24d. (City or town)	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED HARRIS, JAMES		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1892		5. PLACE OF BIRTH Maryland	
6. OCCUPATION Farmer		7. MARITAL STATUS Married		8. EDUCATION High School		9. COLOR White		10. RELIGION Methodist	
11. CAUSE OF DEATH Heart Disease		12. PLACE OF DEATH Home		13. DATE OF DEATH Aug 5, 1957		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN J. H. Smith	
16. SIGNATURE OF REGISTRAR J. H. Smith		17. SIGNATURE OF WITNESS J. H. Smith		18. SIGNATURE OF WITNESS J. H. Smith		19. SIGNATURE OF WITNESS J. H. Smith		20. SIGNATURE OF WITNESS J. H. Smith	

BUREAU V. 3

AUG 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

Dr. Beck

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08217

08164

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A.A. Co. ru del MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. #1 Edgewater Md. X 2				d. STREET ADDRESS Rt. 1 Box 180			
3. NAME OF DECEASED (Type or print) First HAROLD Middle A. Last TRAFTON		4. DATE OF DEATH Month 8 Day 31 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1890	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer				10b. KIND OF BUSINESS OR INDUSTRY Communications		11. BIRTHPLACE (State or foreign country) Mass.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lorenzo George Trafton				14. MOTHER'S MAIDEN NAME Clara I. Gilcrease			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1917-1919		17. INFORMANT Evelyn Trafton #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 144X DUE TO CARCINOMA OF DUCAL MUCOSA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 YEAR (c)							INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/5, 1957 , to 8/31, 1957 , that I last saw the deceased alive on 8/31, 1957 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Arlington Va. DATE SIGNED 9/3/57							
ACTUAL SIGNATURE Edward H. Beck M.D.		PHYSICIAN'S NAME (Type) Edward H. Beck					
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF 9/4/57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l.		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR 9/4/57		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JANUARY 10, 1957	
AGE		SEX	
65		Male	
RACE		RELIGION	
White		Protestant	
BIRTH DATE		BIRTH PLACE	
JANUARY 10, 1892		BALTIMORE, MARYLAND	
EDUCATION		OCCUPATION	
High School		None	
MARRIAGE DATE		MARRIAGE PLACE	
None		None	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
IMMEDIATE CAUSE		INTERMEDIATE CAUSE	
Myocardial Infarction		Coronary Artery Disease	
PREVAILING DISEASE		PREVAILING DISEASE	
Coronary Artery Disease		Coronary Artery Disease	
DATE OF EXAMINATION		PLACE OF EXAMINATION	
JANUARY 10, 1957		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JANUARY 10, 1957		JANUARY 10, 1957	

BUREAU V. 1

6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08218

Reg. Dist. No.

08220

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Delaware</u> <u>D.C.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSON</u>		c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				d. STREET ADDRESS <u>(803 Aspen St., N.W.)</u> <u>ASPEN + 4th St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Richard.</u> Middle <u>H.</u> Last <u>Jr. Trotter</u>				4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/27/1940</u>		9. AGE (In years last birthday) <u>17</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration ---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Assistant</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>			
13. FATHER'S NAME <u>Richard H. Trotter, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Nicholson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-52-8312</u>		17. INFORMANT Address <u>Richard H. Trotter, Sr. - 803 Aspen St., N.W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compd. Fracture. Skull</u> <u>816X</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident Rt. #2</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>5-17</u> <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>A.A. Co.</u>		20g. (County) <u>A.A. Co.</u>		20h. (State) <u>A.A. Co.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-17-57</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Prince Georges County, Md.</u>		22e. (State) <u>Md.</u>		22f. (Country) <u>U.S.A.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. - 2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>AUG 20 '57</u>			
24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>				24c. (City or town) <u>Washington 9, D.C.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 20 1957

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08221

CERTIFICATE OF DEATH

08219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2yrs.4mo.6days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State				d. STREET ADDRESS 5806 Sheriff Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Verg Middle Twitty Last Twitty				4. DATE OF DEATH Month 8-25- Day 19 Year 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH ?	
9. AGE (In years last birthday) 76? yrs.		IF UNDER 1 YEAR Months 76? Days 76? Hours 76? Min. 76?		IF UNDER 24 HRS. Months 76? Days 76? Hours 76? Min. 76?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wash Twitty				14. MOTHER'S MAIDEN NAME Adeline Twitty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Hospital Records				Address Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) ---							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---				20f. (City or town) (County) (State) ---			
21. I certify that I attended the deceased from 8-6- , 19 57 , to 8-25- , 19 57 , that I last saw the deceased alive on 8-25- , 19 57 , and that death occurred at 3:10p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 8-26-57							
ACTUAL SIGNATURE Conwell Newton, M.D. M.D. Crownsville, Maryland DATE SIGNED 8-26-57							
PHYSICIAN'S NAME (Type) Conwell Newton, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Laurens S.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose B. Boyd				ADDRESS 1238-20th St. N.W.			
24a. REC'D BY REGISTRAR ---				24b. REGISTRAR'S SIGNATURE H. M. J. J. J.			

BUREAU V. S.

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08222 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Item 14, Film G219, 8/23/57

Reg. Dist. No.

08220 74

1. PLACE OF DEATH a. COUNTY <u>ANN ARUNDIEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANN ARUNDIEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>#307-1st Ave. S.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola Wolf Volkhard</u>		4. DATE OF DEATH <u>August 9 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 28 1897</u>
9. AGE (In years last birthday) <u>60</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pierce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Robert Volkhard - Glen Burnie</u>		Address <u>#307 1st Ave. S.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 420.1 DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Hypertension, Arterial Essential</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>4 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, Arterial Essential</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>a.m.</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>5/10</u> , 19 <u>50</u> , to <u>8/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/12</u> , 19 <u>57</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R.W. Prichard</u>		DATE SIGNED <u>8/19/57</u>	
PHYSICIAN'S NAME (Type) <u>R.W. PRICHARD M.D.</u>		ADDRESS (Street, city or town, state) <u>715 Cotton Rd Glen Burnie Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>August 12, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Funeral Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chester, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>J. Deady</u>	
DATE <u>AUG 15 1957</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF BIRTH <i>Jan 15 1912</i>		6. PLACE OF BIRTH <i>Baltimore, Md.</i>	
7. DATE OF DEATH <i>Aug 15 1957</i>		8. PLACE OF DEATH <i>Home</i>	
9. TIME OF DEATH <i>10:30 AM</i>		10. CAUSE OF DEATH <i>Heart Disease</i>	
11. DISEASE OR INJURY <i>Myocardial Infarction</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		14. SIGNATURE OF DEATH REGISTRAR <i>John Doe</i>	
15. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		16. SIGNATURE OF FUNERAL HOME <i>John Doe</i>	
17. SIGNATURE OF BURIAL PLACE <i>John Doe</i>		18. SIGNATURE OF OTHER <i>John Doe</i>	
19. SIGNATURE OF OTHER <i>John Doe</i>		20. SIGNATURE OF OTHER <i>John Doe</i>	
21. SIGNATURE OF OTHER <i>John Doe</i>		22. SIGNATURE OF OTHER <i>John Doe</i>	
23. SIGNATURE OF OTHER <i>John Doe</i>		24. SIGNATURE OF OTHER <i>John Doe</i>	
25. SIGNATURE OF OTHER <i>John Doe</i>		26. SIGNATURE OF OTHER <i>John Doe</i>	
27. SIGNATURE OF OTHER <i>John Doe</i>		28. SIGNATURE OF OTHER <i>John Doe</i>	
29. SIGNATURE OF OTHER <i>John Doe</i>		30. SIGNATURE OF OTHER <i>John Doe</i>	
31. SIGNATURE OF OTHER <i>John Doe</i>		32. SIGNATURE OF OTHER <i>John Doe</i>	
33. SIGNATURE OF OTHER <i>John Doe</i>		34. SIGNATURE OF OTHER <i>John Doe</i>	
35. SIGNATURE OF OTHER <i>John Doe</i>		36. SIGNATURE OF OTHER <i>John Doe</i>	
37. SIGNATURE OF OTHER <i>John Doe</i>		38. SIGNATURE OF OTHER <i>John Doe</i>	
39. SIGNATURE OF OTHER <i>John Doe</i>		40. SIGNATURE OF OTHER <i>John Doe</i>	
41. SIGNATURE OF OTHER <i>John Doe</i>		42. SIGNATURE OF OTHER <i>John Doe</i>	
43. SIGNATURE OF OTHER <i>John Doe</i>		44. SIGNATURE OF OTHER <i>John Doe</i>	
45. SIGNATURE OF OTHER <i>John Doe</i>		46. SIGNATURE OF OTHER <i>John Doe</i>	
47. SIGNATURE OF OTHER <i>John Doe</i>		48. SIGNATURE OF OTHER <i>John Doe</i>	
49. SIGNATURE OF OTHER <i>John Doe</i>		50. SIGNATURE OF OTHER <i>John Doe</i>	
51. SIGNATURE OF OTHER <i>John Doe</i>		52. SIGNATURE OF OTHER <i>John Doe</i>	
53. SIGNATURE OF OTHER <i>John Doe</i>		54. SIGNATURE OF OTHER <i>John Doe</i>	
55. SIGNATURE OF OTHER <i>John Doe</i>		56. SIGNATURE OF OTHER <i>John Doe</i>	
57. SIGNATURE OF OTHER <i>John Doe</i>		58. SIGNATURE OF OTHER <i>John Doe</i>	
59. SIGNATURE OF OTHER <i>John Doe</i>		60. SIGNATURE OF OTHER <i>John Doe</i>	
61. SIGNATURE OF OTHER <i>John Doe</i>		62. SIGNATURE OF OTHER <i>John Doe</i>	
63. SIGNATURE OF OTHER <i>John Doe</i>		64. SIGNATURE OF OTHER <i>John Doe</i>	
65. SIGNATURE OF OTHER <i>John Doe</i>		66. SIGNATURE OF OTHER <i>John Doe</i>	
67. SIGNATURE OF OTHER <i>John Doe</i>		68. SIGNATURE OF OTHER <i>John Doe</i>	
69. SIGNATURE OF OTHER <i>John Doe</i>		70. SIGNATURE OF OTHER <i>John Doe</i>	
71. SIGNATURE OF OTHER <i>John Doe</i>		72. SIGNATURE OF OTHER <i>John Doe</i>	
73. SIGNATURE OF OTHER <i>John Doe</i>		74. SIGNATURE OF OTHER <i>John Doe</i>	
75. SIGNATURE OF OTHER <i>John Doe</i>		76. SIGNATURE OF OTHER <i>John Doe</i>	
77. SIGNATURE OF OTHER <i>John Doe</i>		78. SIGNATURE OF OTHER <i>John Doe</i>	
79. SIGNATURE OF OTHER <i>John Doe</i>		80. SIGNATURE OF OTHER <i>John Doe</i>	
81. SIGNATURE OF OTHER <i>John Doe</i>		82. SIGNATURE OF OTHER <i>John Doe</i>	
83. SIGNATURE OF OTHER <i>John Doe</i>		84. SIGNATURE OF OTHER <i>John Doe</i>	
85. SIGNATURE OF OTHER <i>John Doe</i>		86. SIGNATURE OF OTHER <i>John Doe</i>	
87. SIGNATURE OF OTHER <i>John Doe</i>		88. SIGNATURE OF OTHER <i>John Doe</i>	
89. SIGNATURE OF OTHER <i>John Doe</i>		90. SIGNATURE OF OTHER <i>John Doe</i>	
91. SIGNATURE OF OTHER <i>John Doe</i>		92. SIGNATURE OF OTHER <i>John Doe</i>	
93. SIGNATURE OF OTHER <i>John Doe</i>		94. SIGNATURE OF OTHER <i>John Doe</i>	
95. SIGNATURE OF OTHER <i>John Doe</i>		96. SIGNATURE OF OTHER <i>John Doe</i>	
97. SIGNATURE OF OTHER <i>John Doe</i>		98. SIGNATURE OF OTHER <i>John Doe</i>	
99. SIGNATURE OF OTHER <i>John Doe</i>		100. SIGNATURE OF OTHER <i>John Doe</i>	

BUREAU V. 3

AUG 15 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, on page 3 of this certificate, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,9 FilmG219 8-12-57 et

CERTIFICATE OF DEATH

08223

08221

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. LENGTH OF STAY IN 1b <u>1 month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>North Shore (Private home)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Robinson Warner</u>				4. DATE OF DEATH Month Day Year <u>Aug 2 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9 1878</u>	9. AGE (In years last birthday) yrs. <u>79 8/10</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto. city</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>NELSON ROBINSON</u>				14. MOTHER'S MAIDEN NAME <u>TINA STIFF</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Elizabeth Tober Warner</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>senility (arteriosclerosis)</u> (c) <u>Cachexia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>4 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Aug 2</u> , 19 <u>57</u> , to <u>Aug 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>did not see alive</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR. MOUNTAIN RD. PASADENA MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				24a. REC'D BY REGISTRAR <u>10/6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>	

AUG 6 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film 220 9-11-57 et

08165

CERTIFICATE OF DEATH

08222 21

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Pasadena Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp</u>				d. STREET ADDRESS <u>1 Pasadena Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Preston</u> First Middle Last <u>ELNathen Watts</u>				4. DATE OF DEATH <u>8-28-57</u> Month Day Year <u>19</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-27-1899</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shovel Operator State Roads</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Glen Burnie Md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>William Theodore Watts</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA Stuchcomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-18-4157</u>			
				17. INFORMANT Address <u>Wife Mrs Watts Pasadena Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>416 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Rheumatic Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8-24-57</u> , 19 <u>57</u> , to <u>8-28-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8-22-57</u> , 19 <u>57</u> , and that death occurred at <u>5:40 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>8-28-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug. 31, 1957</u>		<u>Glen Haven Memorial</u>		<u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 3 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Am J Stuchcomb</u>			

BUREAU V. 1

SEP 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

08166

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.CO.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u> c. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE, MD. #2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Susie MAE WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>5 1 19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894 11-9-1893</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE BOWMAN</u>		14. MOTHER'S MAIDEN NAME <u>BAMAH TARYSLEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>MRS. HENRY NOWOTNICK #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (a), stating the underlying cause last. DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>8/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-3-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Gyer + Mrs Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>8/2/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>J. J. ...</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
AUG 5 1957
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 3 hours.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie X/			d. STREET ADDRESS Wellham Ave. and Wilson Lane
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Drifwood Tavern				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank James Middle Witkowski Last 				4. DATE OF DEATH Month August Day 1st. Year 1957			
5. SEX M	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/03		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Farm			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Steven Witkowski				14. MOTHER'S MAIDEN NAME Josephine Cichocki			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-2545		17. INFORMANT Address Miss. Agnes B. Witkowski (sister)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gustave H. Faubert				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/1/57		8/1/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG 5, 1957		22c. NAME OF CEMETERY OR CREMATORY NO 4 ROSARY		22d. LOCATION (City, town, or county) (State) 7335 GERMAN Hill Rd	
23. FUNERAL DIRECTOR'S SIGNATURE George A. Weber 705 S. Ann st				ADDRESS 		24. REC'D BY REGISTRAR 1957 25. REGISTRAR'S SIGNATURE L. J. Adley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the cause of the delay in the space provided. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALANCE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

BUREAU V. S.

AUG 6 1957

RECEIVED

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1
1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08225

08225

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN TB 9yrs. 8mo. 30da.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State				d. STREET ADDRESS 1700 Latrobe Street					
3. NAME OF DECEASED (Type or print) First John Middle Witlock Last (Whitlock)				4. DATE OF DEATH Month 8 Day 31- Year 1957					
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> unk DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown			
9. AGE (In years last birthday) 60? yrs.		IF UNDER 1 YEAR Months 60?		IF UNDER 24 HRS. Days 60?		Hours 60?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) unknown		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Lizzie Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Hospital Records Address Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition and Dehydration								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Crownsville				20g. (County) ...		20h. (State) ...			
21. I certify that I attended the deceased from July 1, 19 57, to August 31, 19 57, that I last saw the deceased alive on 8-31- 19 57, and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 9-3-57									
ACTUAL SIGNATURE Lionel McHenry Mapp				M.D. Crownsville, Maryland					
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) SEPT-7-1957		22b. DATE THEREOF SEPT-7-1957		22c. NAME OF CEMETERY OR CREMATORY St. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Acco			
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders				24a. REC'D BY REGISTRAR 4/6/57		24b. REGISTRAR'S SIGNATURE St. M. Joyce			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		45		Male	
Date of Death		Place of Death		Cause of Death	
10/15/1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Registrar		Signature of Informant	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		Cause of Death	
10/15/1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	

BUREAU V. 2

SEP 9 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 08226									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Same b. COUNTY Same				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum			c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Same				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 305 Regency Circle					d. STREET ADDRESS 1 Same			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Broadus Lee Wood					4. DATE OF DEATH Month Day Year August 9 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/22/93		9. AGE (In years last birthday) 63 yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired leather roller			10b. KIND OF BUSINESS OR INDUSTRY LEATHER		11. BIRTHPLACE (State or foreign country) Boonesville, Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Lee Wood					14. MOTHER'S MAIDEN NAME Florence Hall				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES			16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W W I 235-05-3251		17. INFORMANT Earl Wood (son)			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976x Multiple fractures of skull due to self DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) inflicted wound with a 12 gauge shot gun. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Se #18						
20c. TIME OF INJURY Month, Day, Year 4:30 a.m. 8/9/57 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Linthicum A.A. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Gustave H. Faubert, M.D.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/9/57 8/9/57				
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.					DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Aug 11, 1957		22c. NAME OF CEMETERY OR CREMATORY PRIZE HILL			22d. LOCATION (City, town, or county) (State) BOONESVILLE, VA.		
23. FUNERAL DIRECTOR'S SIGNATURE George J. Honce					ADDRESS 4001 Ritchie Hwy		24a. REC'D BY REGISTRAR AUG 15 '57		24b. REGISTRAR'S SIGNATURE A. H. Smith

BUREAU V. S.

AUG 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08167

CERTIFICATE OF DEATH

08227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>		d. STREET ADDRESS <u>213 Lockwood Court</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Lee</u> Last <u>WOOD</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 June 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Bld.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Benjamin F. WOOD</u>		14. MOTHER'S MAIDEN NAME <u>Annie BOWEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-4707</u>	
17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Massive</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mural Thrombi, right ventricular</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 August</u> , 19 <u>57</u> , to <u>6 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6 August</u> , 19 <u>57</u> , and that death occurred at <u>6:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>U.S. Naval Hospital, Annapolis, Md. 8-7-57</u>	
PHYSICIAN'S NAME (Type) <u>D. R. BAHNER, LT. MC. USNR</u>			
22a. BYRIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8-9-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR DATE <u>8/7/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Aug 8 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08228

08168

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drexil Hill</u> 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>		d. STREET ADDRESS <u>724 Collenbrook Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>(n)</u> Last <u>WYCHERLEY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>21 SEPT 1885</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy - Retired</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>England</u>	
13. FATHER'S NAME <u>Herbert WYCHERLEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia HARTLEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1/2</u> hour		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>24 May</u> , 19 <u>57</u> , to <u>8 August</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8 August</u> , 19 <u>57</u> , and that death occurred at <u>11:05 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Mc Roberts</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u> DATE SIGNED <u>8-9-57</u>	
PHYSICIAN'S NAME (Type) <u>J. W. MC ROBERTS</u>		Lieutenant, Medical Corps, U. S. Navy	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	
24a. REC'D BY REGISTRAR <u>AUG 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John J. [Signature]</u>	

BUREAU V. S.

12 1957

RECEIVED